University Hospitals of Morecambe Bay NHS Foundation Trust

Royal Lancaster Infirmary

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	**Requires improvement**
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Requires improvement
Maternity and gynaecology	Requires improvement
Services for children and young people	Requires improvement
End of life care	Good
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Lancaster Infirmary is one of three locations providing care as part of University Hospitals of Morecambe Bay NHS Foundation Trust. It provides a full range of hospital services including emergency care, critical care, a comprehensive range of elective and non-elective general medicine (including elderly care) and surgery, an oncology unit, a neonatal unit, children and young people's services, maternity services and a range of outpatient and diagnostic imaging services.

University Hospitals of Morecambe Bay NHS Foundation Trust provides services for around 360,000 people across North Lancashire and South Cumbria with over 700 beds. In total, the Royal Lancaster Infirmary has 426 beds.

We inspected University Hospitals of Morecambe Bay NHS Foundation Trust as part of our comprehensive inspection programme in February 2014. Following our inspection in February 2014 we rated the Royal Lancaster Infirmary as 'Requires Improvement' overall. We judged the hospital as 'Requires improvement' for safe, effective, responsive and well led and 'good' for caring. CQC was specifically concerned about staffing levels particularly in medical services (Ward 39) but also in other clinical areas such as the surgical wards, radiology, dermatology and paediatrics, where there was a shortage of specialist staff. We also found the trust's governance and management systems were inconsistently applied across services and the quality of performance management information required improvement.

We carried out this inspection to see whether the hospital had made improvements since our last inspection. We carried out an announced inspection of Royal Lancaster Infirmary on 15 July 2015. In addition an unannounced inspection was carried out between 4pm and 7:30pm on 29 July 2015. As part of the unannounced visit we looked at the care provided on Ward 39 and the acute surgical assessment unit.

Overall we rated Royal Lancaster Infirmary as 'Requires Improvement'. We have judged the hospital as 'good' for caring. We found that services were provided by dedicated, caring staff and patients were treated with dignity and respect. However improvements were needed to ensure that services were safe, effective, well led and responsive to people's needs.

Our key findings were as follows:

Cleanliness and infection control

- The trust had infection prevention and control policies in place which were accessible to staff.
- We observed good practices in relation to hand hygiene. 'Bare below the elbow' guidance was followed and personal protective equipment, such as gloves and aprons, was used appropriately while delivering care.
- 'I am clean' stickers were used to inform staff at a glance that equipment or furniture had been cleaned and was ready for use.
- Patients received care in a clean, hygienic and suitably maintained environment. Staff were aware of and applied infection prevention and control guidelines.
- However, in the emergency department ,we saw some dusty equipment and shelving. We also found that inside a cupboard containing medical supplies was dirty. Some cubicle floors were dirty and there was debris on the floors. We inspected six mattresses and noted that four of them had holes in the covers and there was evidence of staining on the inside and onto the foam mattress itself. We later observed staff conducting a full audit of the mattresses.
- Between December 2014 and June 2015 there had been one case of MRSA in medical care services. There had been six cases of Clostridium difficile (C.diff) reported in the medical division in the same period. Four of these were avoidable. Meetings had taken place regarding these incidents that included looking at lessons learnt.
- Between April 2014 and February 2015 there had been three avoidable cases of C.diff in the surgical and critical care division at Royal Lancaster Infirmary. There had been no learning from these events that had resulted in additional measures to prevent infection.

Summary of findings

- According to the submitted and verified intensive care national audit and research centre data (ICNARC), the critical care unit performed as well and sometimes better than similar units for unit acquired methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile infection rates.

Nurse staffing

- Care and treatment were delivered by committed and caring staff who worked hard to provide patients with good services.
- Although we found staffing levels were adequate at the time of our inspection, there was no flexibility in numbers to cope with increased capacity and demand, or short-notice sickness and absence.
- The trust had actively recruited nursing staff from overseas to try to improve staffing levels. However, there were still staffing shortfalls that were covered by bank and agency staff. Senior staff said they tried to use the same bank and agency staff to ensure that they had the required skills to work on the ward. Agency staff were given an induction before commencing work on the wards.
- Nurses recruited from overseas were supernumerary while they awaited registration with the Nursing and Midwifery Council. However, in surgical services there was a lack of clarity about their role and responsibilities.
- Staffing establishments had improved since the last inspection however on some wards, nurse staffing remained a challenge. Ward 39 in particular, remained a concern. Senior staff felt that the staffing establishment on the ward was unsustainable for the number of beds (50 beds) as they had been asked to reduce the number of clinical support workers. They were unsure how the new staffing figures for clinical support workers had been decided as they had not been involved in the review.
- A review of staffing over a one month period showed that the skill mix on ward 39 did not always fall in line with the trust's 'red rules' initiative. The principals of this initiative included one registered nurse should deliver care to no more than eight patients and the minimum skills mix on a ward should be 60% registered nurses to 40% health care assistants.

Medical staffing

- Medical treatment was delivered by skilled and committed medical staff.
- The trust had identified areas where medical staff shortages presented risk to patient care and treatment and were working hard to recruit and retain consultants.
- There had been an increase in the number of cardiology consultants from two to six. These consultants worked across the trust on a six week rotation basis. This had improved patient care and facilitated earlier discharges. It had also reduced the angiogram waiting list from 18 months to three weeks. However, there was a lack of consultants in some specialist services such as respiratory and gastroenterology.
- Over the past 6 months the locum cover had been as high as 51.5% in some areas. The specialities that had high use of locum cover included elderly care, diabetes, dermatology and rheumatology services.
- There were ongoing vacancies within the radiology service. Managers said they were actively recruiting and had introduced the use of extended roles for advanced practitioners to help manage the case load. The service leads felt there had been some improvements in staffing but the recruitment of experienced radiology staff remained a challenge.
- There was a sufficient number of medical staff to support outpatient services. The majority of clinics were covered by specialist consultants and their medical teams. However, staff said paediatric clinics were frequently cancelled with less than six weeks' notice due to the consultant rota and lack of junior and middle grade doctors.
- Anaesthetic cover was provided by an ST3 (specialist registrar year 3) or above, who was resident on call and provided cover for ITU and the obstetric epidural service; this was supported by a non-resident consultant intensivist. It was acknowledged that this fell short of national guidelines. However, there was no evidence to suggest there were any serious incidents or complaints relating to delays in obtaining an anaesthetist.

Mortality rates

Summary of findings

- The trust was highlighted as a 'risk' for the in-hospital mortality indicator - Cerebrovascular conditions in the CQC Intelligent monitoring report May 2015.
- Mortality and morbidity meetings were held either weekly or monthly and were attended by representatives from teams within the relevant divisions. As part of these meetings, attendees reviewed the notes for patients who had died in the hospital within the previous week. Any learning identified was shared and applied.

Nutrition and hydration

- Patients had a choice of nutritious food and an ample supply of drinks during their stay in hospital. Patients with specialist needs in relation to eating and drinking were supported by dieticians and by the speech and language therapy team.
- Patient records included an assessment of patients' nutritional requirements based on the malnutrition universal screening tool (MUST).
- However, in medical care services, people were not always supported appropriately with their nutritional needs. For example, a patient on ward 39 required feeding via a gastro-enteric tube. There was a clear plan in place which outlined what the food and fluid intake should be for this patient including specified volumes and times for delivery. On checking the daily fluid monitoring chart the daily intake recorded did not match the amount stated on the plan for three days.
- Where patients were identified as being at risk, there were fluid and food charts in place. However, the recording of fluid balance charts was inconsistent, particularly in medical care services.
- Parents told us there was a good selection of food on the menu for children and young people. Children were also offered snacks and food was available as it was required.

There were areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure that all premises used by the service provider are suitable for the purpose for which they are being used and properly maintained. This is particularly in relation to physiotherapy services and medical care services provided from medical unit one.
- Ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet the needs of the patients. Staff should receive appropriate support, training and appraisal as is necessary to enable them to carry out their role.
- Ensure that staff understand their responsibilities under and act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- Ensure that staff follow policies and procedures around managing medicines, including intravenous fluids particularly in medical care services and critical care services.
- Ensure that the resuscitation trolleys on the children's ward are situated in areas that make them easily accessible in an emergency. All staff must be clear on who has responsibility for the maintenance of the resuscitation trolley on the delivery suite.
- Ensure that they maintain an accurate, complete and contemporaneous record in respect of each service user.
- The provider must ensure that the Five Steps to Safer Surgery (World Health Organisation) safety checklist is consistently followed and fully embedded in obstetric theatre practice.
- The provider must ensure that all staff comply with hand hygiene requirements.
- Ensure referral to treatment times in surgical specialities improve

In addition the trust should:

In urgent and emergency services:

Summary of findings

- Ensure all areas in the emergency department are clean and free from dust and debris and that mattresses are fit for purpose..
- Take action to improve waiting times and ambulance handovers.
- Ensure action plans following CEM audits clearly state the steps required to secure improvement.
- Improve staff engagement, knowledge and awareness of the strategy for the service.

In medical care services:

- Ensure that call bells are easily accessible for patients so they can call for help when required.
- Ensure there are clear plans in place to reduce the number of falls occurring within the service.
- Improve the management of people with a stroke in line with national guidance.
- Consider improving arrangements for clinical supervision to ensure they are appropriate and support staff to effectively carry out their responsibilities, offer relevant development opportunities and enable staff to deliver care safely and to an appropriate standard.
- Take action to improve reduce the number of patients staying on medical wards that are not best suited to their needs and to reduce the number of moves between wards.

In surgical services:

- Ensure there are systems in place to identify themes from incidents and near miss events to promote safe care.
- Ensure all theatres are completing audits to monitor compliance with the 5 steps to safer surgery process.
- Ensure all staff understand the process for raising safeguarding referrals in the absence of the safeguarding lead.
- Reduce and improve readmission rates.
- Ensure all procedures are performed in line with best practice guidance. Where practice deviates from the guidance, a clear risk assessment should be in place.
- Continue to engage staff and encourage team working to develop and improve the culture within the theatre department.

In critical care services:

- Ensure that there is timely access to medical care for patients out of hours and that any delays do not result in patient harm.
- Consider how it is going to improve performance in reducing the number of delayed and out of hours discharges of patients from critical care.
- Ensure that any delayed discharges from critical care do not result in a breach of the government's single sex standard.
- Ensure that all entries in patient records are appropriately signed and dated.
- Consider the provision of a supernumerary clinical coordinator on duty 24/7.

In maternity and gynaecology services:

- Ensure that the actions of the Kirkup recommendations are implemented within timescales and embedded across the trust
- Ensure there are clear lines of responsibility and accountability at ward manager and matron level within maternity so that staff feel supported and barriers to communication and change are removed
- Implement the recommendations of and monitor compliance with, the PHSO Report 'Midwifery supervision and regulation: recommendations for change' (2013) with regard to Trust/Midwifery Supervisory investigations, so that parent(s) receive a joint set of recommendations and a single timeframe resulting from the investigation
- Ensure that the 'Five steps to safer surgery' (World Health Organisation) is embedded in obstetric theatre practice.
- Ensure that a physical test is carried out in line with trust policy to ensure that the infant abduction procedures work correctly and that staff understand how they work

Summary of findings

In children and young people's service:

- Ensure that there are clearly defined and formalised job plans in place for consultant paediatricians.
- Consider reviewing the investigation process of patient safety incidents with full consideration given to the reporting professional's account of events and concerns.
- Ensure there is sufficient and appropriate access to oxygen points on the neonatal unit in line with BAPM standards.

In end of life care services:

- Ensure there is a clear and accessible system in place to identify and monitor risks within end of life care services.
- Continue to take action to improve those areas identified by the NCDAH.
- Ensure all DNACPR forms are completed to the appropriate standard.

In outpatients and diagnostic imaging:

- Continue to build relationships and improve closer team working to develop a one trust culture.

Professor Sir Mike Richards Chief Inspector of Hospitals

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Some areas, including flooring in the cubicles, within the emergency department were dusty and dirty. Four of the six mattresses we inspected had damaged covers and were stained. The patient's allergy status had not been completed in 11 out of the 22 records we reviewed. Mandatory training completion levels were below the trust's target. From April 2014 to April 2015 the trust had struggled to meet the Department of Health four hour access target. Royal Lancaster Infirmary had experienced 674 black breaches from March 2014 to March 2015, whereby the time from an ambulance's arrival to the patient being formally handed over to the department was longer than 60 minutes. None of the staff we spoke with could articulate the current strategy and vision for the service. The department had a risk register, which identified risks and control measures to mitigate these. Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history. There was little evidence of innovation and cross – departmental working with the emergency department at Furness General Hospital. Staff were motivated and described a supportive team-working environment. However, none of the staff we spoke with felt they had been actively engaged or that their views were reflected in the planning and delivery of services. The trust had identified this as an area for improvement. The emergency department provided a caring and compassionate service. Staff treated patients with dignity and respect. The department was accessible for people with limited mobility and people who used a wheelchair. There were systems in place to support people living with dementia however; staff told us they had received little guidance on how to support patients with a learning disability. There were a range of pathways that complied with the National Institute for Health and Care Excellence (NICE) guidelines and the College of Emergency

Summary of findings

Medicine's (CEM) clinical standards for emergency departments. The unplanned re-attendance rate to the emergency department within seven days of discharge (January 2013 to January 2015) was consistently better than the England average. The department had achieved mixed outcomes in the College of Emergency Medicine (CEM) 2014 audits on severe sepsis and septic shock and assessing cognitive impairment in older people, with some areas performing worse than the national average. Action plans were in place to address the areas for improvement.

Medical care

Requires improvement

Following our inspection in 2014 we rated the hospital as inadequate for medical care. As part of that inspection we identified that staffing levels, skill mix, systems and processes all required improvement to secure and maintain the safety and effectiveness of the service. There were particular concerns about nurse staffing levels and skill mix on Ward 39. The quality of nursing records required improvement and some patient records and risk assessments were incomplete. Wards and departments were not always well-led at a senior level and there was a disconnect between the staff providing care and the executive team.

We found that although significant changes had been made to improve the medical care services, further improvement was still required. Staffing establishments had improved however on some wards, nurse staffing remained a challenge. Staff recruitment was in progress to fill staff vacancies but there were still medical staffing vacancies in some specialities. Safety data indicated that there were a high number of falls but it was not clear what action had been taken as a result. Nurse record keeping had improved but completion of care records was still variable and recording of fluid balance charts was inconsistent. Medical decisions were not always recorded in patient notes and some medical entries in patient records were illegible. There were systems in place to support people living with dementia however; staff told us that there had been difficulties in accessing mental health services. We found that staff members' understanding and awareness of the need to assess

Summary of findings

people's capacity to make decisions about their care and treatment were variable. Staff did not always follow capacity assessment processes in line with trust policy.
Recent national audits indicated that although there had been progress, the service still needed to make improvements to the care and treatment of people who had suffered a stroke. Most staff said they were supported effectively but the appraisal completion rate was below the trust target of 90%.
The bed occupancy rate for the hospital had been consistently above 90% over the six months prior to inspection. There were a number of patients who experienced multiple ward moves during their stay. There were also a high number of patients placed on wards that were not best suited to meet their needs (medical outliers). Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history. Divisional governance board meetings were held on a monthly basis. Minutes from the meetings showed that a monthly report, which included risk registers, mortality incidents, audits and safety alerts, was discussed at the meeting. However, it was not always clear how the learning was then cascaded to ward staff or whether it had already been shared.
The visibility of senior management had improved since the last inspection. The trust was working in partnership with other organisations to help meet the needs of people. Staff were committed and passionate about providing good quality care. Patients told us staff were caring, kind and respected their wishes. We saw staff interactions with people were person-centred.

Surgery **Requires improvement**

Following our last inspection we rated surgical services at the Royal Lancaster Infirmary as "Good" overall.
At this inspection we have rated the services as "Requires Improvement". This is because there was no system for identifying themes from incidents and sharing actions to prevent recurrence. The written policies and procedures for medicine administration, which were being used by staff at

Summary of findings

the time of the inspection, were out of date. However, the electronic versions were in date.There was a high nursing and theatre staff vacancy rate resulting in a high use of agency staff. Not all practices and procedures in operating theatres or the ward areas were based on the relevant guidance. Evidence was gathered for audit of care and treatment but the outcomes and resulting actions were not known to all relevant staff which limited the opportunity to learn.
Readmission rates (after surgery) were worse than the England average. Patients with a hip fracture were not seen by an ortho-geriatrician within timescales which were in line with national guidance. Appraisal rates for staff were lower than the trusts' target. There was a lack of clarity of the role for overseas nursing staff whilst awaiting their registration to practice in the UK. Staff were not clear how the mental capacity of a patient impacted on their role. Referral to treatment times for patients admitted to the hospital were worse than the England average; however trust wide initiatives had been launched to reduce these and improvements had been made.
However, the environment and equipment were visibly clean and tidy with good infection control measures in place. Measures were in place to assess and respond to patient risk. There was a low medical staff vacancy rate and there was effective internal and external multi-disciplinary working. Patients spoke very highly of the attitude of staff and told us that staff treated patients with respect and attended to patients quickly when they requested assistance.

Critical care **Requires improvement** 

Following the last inspection in February 2014, we found that overall the critical care service provided at the Royal Lancashire Infirmary was good. However, at this inspection we have judged that the critical care service required improvement particularly in the areas of safety and responsiveness. There were sufficient numbers of suitably skilled nursing staff to care for the patients. However, there was no commissioned supernumerary nurse on duty and the unit did not have any funded practice educators in post. There was access to a consultant and middle grade

Summary of findings

anaesthetist at all times although out of hours the on call anaesthetist had responsibilities for other specialities, such as maternity. We found that drugs and intravenous fluids were not always stored securely.
When people required intensive care there were no significant delays in that care being delivered, however, there was often a delay in discharging patients once they had been judged as medically fit for discharge. This often also resulted in a breach of the Department of Health's single sex accommodation standard. The clinical area had limited space and fell short of the most recent health building note specifications (HBN-04-02) in relation to infection control isolation rooms. There were no clearly defined plans available for how this shortfall was to be addressed. Additionally there were occasions when owing to capacity and bed availability, patients requiring critical care were looked after in the theatre recovery area.
The unit continued to collect and submit data for the intensive care national audit and research centre (ICNARC) for validation, so it was able to benchmark its performance against comparable units. This data showed that patient outcomes were within the expected ranges when compared with similar units nationally. Critical care services were being delivered by caring, compassionate and committed staff. We saw patients, their relatives and friends being treated with dignity and respect.
The unit did not provide a formally commissioned outreach service. There were robust systems and processes in place for reporting incidents and there was evidence that learning from incidents was disseminated.

Maternity and gynaecology

Requires improvement

At the last inspection in February 2014, we rated maternity and gynaecology services as requiring improvement for being responsive and well led, particularly about patient's access and flow, governance and risk management arrangements and the vision and strategy for the service. During this inspection, we found that although good progress had been made in the implementation of

Summary of findings

recommendations following the Morecambe Bay investigation, maternity services at Royal Lancaster Infirmary required improvement for being safe and well-led.

Processes were in place for infection prevention and control, however, hand hygiene compliance particularly amongst medical staff was low. Audits showed that the 'five steps to safer surgery' procedures (World Health Organization safety checklist) were not completed consistently, and this level of practice was inadequate. Staff were aware of the procedures for safeguarding vulnerable adults and children, however the infant abduction policy had not been tested for some time. Although, the service was caring, the behaviours and attitudes of certain staff were said to be obstructive and created barriers to communication and change.

Midwifery supervision investigations were carried out separately to the trust's investigation process; it was therefore not clear how midwifery supervision investigations and the trust investigations would align.

Governance structures and processes were evolving. There were mixed comments about the effectiveness of leadership. The managerial lines of responsibility and accountability were not clear at ward manager and matron level, which led to confusion and lack of ownership. There was good progress with the completion of actions against the Kirkup recommendations; this work was on-going and areas were yet to be implemented and fully established across the trust.

Medical and midwifery staffing levels were in line with national recommendations for the number of births on the unit each year, although there was high use of midwifery agency staff to cover vacancies, maternity leave and sickness absence. There was no dedicated anaesthetic cover for obstetrics, out of hours cover was provided by a resident trainee anaesthetist who provided cover for maternity and intensive care; this was supported by a non-resident consultant anaesthetist. The service felt this was sufficient for the intensity of the work, although it was accepted that this fell short of national guidelines. The service participated in local and national audits and external peer reviews to improve patient care. Trust outcomes of care for

Summary of findings

women were meeting expectations in most areas and where areas required improvement, action had been taken. Women were treated with dignity and respect.

Services for children and young people

Requires improvement

Following our previous inspection in February 2014, we rated children and young people's services at this hospital as "Requires Improvement". As part of our inspection, we identified issues regarding staffing, resuscitation equipment, poor hand hygiene, incident reporting, pain assessments and the trust's response to audits.

At this inspection we found that incidents were reported appropriately; however a rapid review was completed for patient safety incidents that were identified as moderate, major or catastrophic. As a result not all significant incidents were subject to a thorough investigation where lessons learned could be identified, potentially meaning that incidents could reoccur. For those incidents that did undergo an investigation, the lessons learned had been shared with staff via newsletters and within 'safety huddles'. Medical staffing levels remained an area of concern. Within this inspection we found medical staffing was not at full establishment at the Royal Lancaster Infirmary, and the use of locum cover was still high. There was a high dependency space located at the end of the neonatal unit that did not have a member of staff situated in it at all times. Due to the design and layout of this space and the way in which staff were deployed we found there was a risk that if a baby deteriorated in this area staff would not necessarily be alerted.

There was much improvement in hand hygiene with good practice being observed. At the last inspection there was only one resuscitation trolley on the children's ward which was situated in a side room. As part of this inspection we found this was still the case. However, we were told the trust had purchased two new resuscitation trolleys but only one had been implemented. The trolley was large for the side room it was situated in and would not be easy to remove if the room was occupied. On checking the trolley, we found that some items

were missing. The trust's abduction policy was not being adhered to as it stated a physical test should be carried out on the policy annually but this had not happened for a number of years.
Parents and children were generally satisfied with the care they received and felt they had been kept well informed. They told us staff were compassionate and caring.

End of life care

Good

At the previous inspection in January 2014 we rated the hospital as good for the provision of end of life care. Areas identified for improvement were around the variation in the standard of records in relation to do not attempt cardio-pulmonary resuscitation documentation (DNACPR) and a range of syringe drivers were being used in different areas which was a potential safety hazard. The service was awaiting revised documentation following the withdrawal of the Liverpool Care Pathway. In addition there were concerns the specialist service was available during normal office hours only.
As part of this inspection we found improvements had been made in a number of areas. A replacement advanced care plan had been piloted across two wards and had recently been fully implemented across the trust following a programme of staff training. An audit was completed in January 2015 to check DNACPR documentation. Following the findings of the audit, training had been provided and staff were working on the actions. We did however find some shortfalls in these records particularly around the staff understanding and awareness of how to assess people's capacity to make decisions. Staff were committed and passionate about providing good quality care. There had been an increase in palliative care consultant cover. Staff were aware of the process for incident reporting and could demonstrate learning from incidents. Staff generally felt supported and valued.
Ward 23 had been successful in becoming one of the first acute hospital wards to receive the Gold Standard Framework accreditation. Arrangements for the management of medications were well planned and executed including the prescription of anticipatory medication. Staff spoke positively about the rapid discharge pathway that enabled

patients to be discharged from hospital to home in the last hours/days of their lives. The trust had developed a palliative and end of life strategic plan in line with the 'Better Care Together' strategy which was still in draft form. The nursing and medical staff were working with primary and secondary health care professionals to adopt nationally recognised best practice tools, including the GSF, preferred place of care, priorities for care for the dying person and the advanced care plan. The timeline for implementation was slow however, due to a number of factors including the service being a consultant short and due to the two education end of life posts having ceased.

Outpatients and diagnostic imaging — **Requires improvement**

Since our last inspection we found that there had been some improvements however there were still a shortage of occupational therapists as well as radiologists and staffing shortages in pathology. As part of our last inspection we identified concerns with the timely availability of case notes and test results in the outpatients department. At this inspection staff and managers confirmed that the trust had invested heavily in the medical records storage and provision on site. As a result we found there had been improvements in the availability of case notes.

Space was limited in some areas and the service provision was physically constrained by the existing environment. We visited the physiotherapy department in medical one unit which we found to be cramped and in poor state of repair. Competency assessments were in place for staff working in the radiology department along with temporary staff to the department. However, staff raised concerns about their competencies in CT scanning, due to their rotation into this area being hampered by staff shortages.

Our previous inspection noted that there was no information available in the departments for patients who had a learning disability or written information in formats suitable for patients who had a visual impairment. In the course of this inspection we noted that this was not the case. Main outpatient and the Occupational Therapy department had specific information and leaflets for patients with learning disabilities. Main

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Outpatients and the Ophthalmology department had leaflets in an easy read formats; or written in formats suitable for those patients who have a visual impairment . However, staff we spoke with in outpatient departments across the site were not able to tell us how written information in an 'easy read' format could be accessed.

Senior managers told us the service had experienced issues with effective team working and had challenges in building team resilience and communication. We found examples of temporary leadership roles in place that had led to difficulties in driving forward service innovation and improvement. This was a particular issue in the Breast Screening Unit.

Outpatient and diagnostic services were delivered by caring, committed and compassionate staff. Patients were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes. Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence based and followed national guidance. We found that overall access to appointments had improved but performance was variable.

Royal Lancaster Infirmary

Detailed findings

Services we looked at

Urgent & emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and Gynaecology; Services for children and young people;End of life care; Outpatients & Diagnostic Imaging

Detailed findings

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Background to Royal Lancaster Infirmary

University Hospitals of Morecambe Bay NHS Foundation Trust operates from three main hospital sites: the Furness General Hospital in Barrow, the Royal Lancaster Infirmary and Westmorland General Hospital in Kendal. The Queen Victoria Hospital in Morecambe provides outpatient services and Ulverston Community Health Centre provides nutrition, dietetics and breast screening. This inspection report will focus only on the acute services provided at the Royal Lancaster Infirmary.

The Royal Lancaster Infirmary provides a full range of hospital services including emergency care, critical care, a comprehensive range of elective and non-elective surgery and general medicine (including elderly care), an oncology unit, a neonatal unit, children and young people's services, maternity services and a range of outpatient and diagnostic imaging services.

University Hospitals of Morecambe Bay NHS Foundation Trust became a Foundation Trust on 1 October 2010. The trust provides services for around 360,000 people across North Lancashire and South Cumbria with over 700 beds. In total, the Royal Lancaster Infirmary has 426 beds.

We inspected Royal Lancaster Infirmary as part of our inspection of University Hospitals of Morecambe Bay NHS Foundation Trust. The trust was inspected as part of our comprehensive inspection programme in February 2014. We carried our inspection on 15 July 2015 to see whether the hospital had made improvements since our last inspection.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Deputy Chief Inspector, Care Quality Commission

Head of Hospital Inspections: Ann Ford, Care Quality Commission and Amanda Stanford, Care Quality Commission

The team included a CQC inspection manager, ten CQC inspectors and a variety of specialists including: Head of Clinical Governance, Associate Director of Nursing, Professor of Respiratory Medicine, Consultant Radiologist, Consultant Obstetrician and Gynaecologist, Consultant Paediatrician and Neonatologist Consultant Anaesthetist, Consultant General Surgeon, Consultant in Medicine, Head of Midwifery and Supervisor of Midwives, Matron in neonatal services, Paediatric Nurse, Critical Care Nurse, Paramedic.

Detailed findings

We also had experts by experience who had experience of using healthcare services.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before visiting the hospital, we reviewed a range of information we held about the Royal Lancaster Infirmary and asked other organisations to share what they knew about the hospital. These included the Clinical Commissioning Groups, NHS England, Health Education England, the General Medical Council, the Nursing and Midwifery Council, the Royal Colleges and the local Healthwatch.

We held specific listening events for people using medical care and maternity services on 30 June 2015 in Lancaster and Barrow to hear people's views about care and treatment received at the hospital. Some people also shared their experiences by email or telephone.

The announced inspection of Royal Lancaster Infirmary took place on 15 July 2015. The inspection team inspected the following core services:

- Urgent and Emergency Services
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and gynaecology
- Children and young people's services
- Outpatients and Diagnostic Imaging
- End of life care

During the inspection, we held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, trainee doctors, consultants, midwives, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatients services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We undertook an unannounced inspection between 4pm and 7.30pm on 29 July 2015 at the Royal Lancaster Infirmary. During the unannounced inspection we looked at the care of patients on Ward 39 and the acute surgical admissions unit.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Royal Lancaster Infirmary.

Facts and data about Royal Lancaster Infirmary

The Royal Lancaster Infirmary is one of three locations providing care as part of University Hospitals of Morecambe Bay NHS Foundation Trust. There are 426 beds in total.

University Hospitals of Morecambe Bay NHS Foundation Trust provides services for around 360,000 people across North Lancashire and South Cumbria with over 700 beds.

Cumbria and Lancashire are largely rural regions with a total population of around 1.5million. The 2010 Indices of Deprivation showed Cumbria and Lancashire were the 21st and 22nd most deprived counties (out of 149 counties, with the 1st being the most deprived).

Life expectancy is between 9 and 11 years lower for men and 7 to 8 years lower for women in the most deprived

Detailed findings

areas of Cumbria and Lancashire than in the least deprived areas. Census data shows an increasing population and a lower than average proportion of Black, Asian and Minority Ethnic (BAME) residents.

From January to December 2014 there were 87,772 emergency department attendances and 438,436 outpatient attendances. The trust employs 4,409 members of staff.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Urgent and emergency services

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	**Requires improvement**

Information about the service

Urgent and emergency services are provided at Royal Lancaster Infirmary by the emergency department, which forms part of the acute and emergency medical division. The emergency department (or accident and emergency department), operates 24 hours a day, seven days a week. The emergency department saw 58,070 patients between April 2014 and April 2015 of which 36,422 were children. The average daily attendance rate is 145 patients per day, 1018 patients per week.

Information provided by the trust showed that the number of patients attending the emergency department had reduced over the last few years. In 2010 there were 87,502 attendances,in 2011 there were 89,461 attendances whilst in 2013 there had been 86,177 attendances and in 2014 there had been 84,733 attendances.

The emergency department is a designated trauma unit and provides care for all trauma patients. However, the most severely injured trauma patients will be taken by ambulance or helicopter to the nearest trauma centre in Preston, if their condition allows them to travel directly. If not, they are stabilised at Royal Lancaster Infirmary and either treated or transferred as their condition dictates. There is a protocol to inform the medical team which patient injuries would require treatment at a major trauma centre. The department is served with a helipad.

Emergency department patients receive care and treatment in three main areas: 'minors, 'majors' and resuscitation bays. Self -presenting patients with minor illnesses or injuries are assessed and treated in the 'minors' area. There are two waiting areas, one for patients with minor illness or injury and one separate waiting area for children. Patients with a serious injury or illness who arrive by ambulance are triaged and seen in the 'majors' area or the resuscitation room. The major's area has 10 bays and the resuscitation room has four bays, one of which is equipped for children. The majors' area and resuscitation room is accessed through a dedicated ambulance entrance.

During the inspection we spoke with seven patients, two carers and 23 staff from different disciplines including nurses, doctors, managers, support staff and ambulance staff. We observed daily practice, reviewed paper and electronic records and documentation. Prior to and following our inspection, we reviewed performance information about the trust and reviewed information provided to us from the trust.

Urgent and emergency services

Summary of findings

Some areas, including flooring in the cubicles, within the emergency department were dusty and dirty. Four of the six mattresses we inspected had damaged covers and were stained. The patient's allergy status had not been completed in 11 out of the 22 records we reviewed. Mandatory training completion levels were below the trust's target. From April 2014 to April 2015 the trust had struggled to meet the Department of Health four hour access target. Royal Lancaster Infirmary had experienced 674 black breaches from March 2014 to March 2015, whereby the time from an ambulance's arrival to the patient being formally handed over to the department was longer than 60 minutes.

None of the staff we spoke with could articulate the current strategy and vision for the service. The department had a risk register, which identified risks and control measures to mitigate these. Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history.

There was little evidence of innovation and cross – departmental working with the emergency department at Furness General Hospital. Staff were motivated and described a supportive team-working environment. However, none of the staff we spoke with felt they had been actively engaged or that their views were reflected in the planning and delivery of services. The trust had identified this as an area for improvement.

The emergency department provided a caring and compassionate service. Staff treated patients with dignity and respect. The department was accessible for people with limited mobility and people who used a wheelchair. There were systems in place to support people living with dementia however; staff told us they had received little guidance on how to support patients with a learning disability. There were a range of pathways that complied with the National Institute for Health and Care Excellence (NICE) guidelines and the College of Emergency Medicine's (CEM) clinical standards for emergency departments. The unplanned re-attendance rate to the emergency department within seven days of discharge (January 2013 to January 2015) was consistently better than the England average. The department had achieved mixed outcomes in the College of Emergency Medicine (CEM) 2014 audits on severe sepsis and septic shock and assessing cognitive impairment in older people, with some areas performing worse than the national average. Action plans were in place to address the areas for improvement.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

The emergency department was mostly tidy and we saw cleaning in progress during the visit. However, some equipment and shelving was dusty. We found the inside of a cupboard containing medical supplies was dirty and some cubicle floors were also dirty. We inspected six mattresses and noted that four of them had holes in the covers and there was evidence of staining on the inside and onto the foam mattress.

Documentation was not always fully completed. Medicines were stored securely however; there was no formal system to record when drugs (other than controlled drugs) were brought into the department by patients. The patient's allergy status had not been completed in 11 out of the 22 records we reviewed. Mandatory training completion levels were below the trust's target. There were ongoing nursing and medical staff vacancies.

Incidents

- There was a strong culture of reporting, investigating and learning from incidents.
- Staff used an electronic system to report incidents, which were sent automatically to the unit manager and clinical lead. Staff were encouraged to report incidents and staff told us they knew how to use the system.
- Serious incidents were reported through the Strategic Executive Information System (STEIS). Five serious incidents were reported to STEIS between May 2014 and April 2015. All serious incidents were investigated using a root cause analysis approach and action plans were implemented as a result.
- Staff told us they received feedback from incidents via email and through discussion with their manager. Staff involved in an incident were encouraged to write a reflection about the incident to enhance their learning. Learning from incidents was also discussed in the nursing handover at the beginning of each shift, within the monthly governance meeting and in the consultant meetings. A newsletter had been produced to inform staff of incidents and there was a folder that staff were encouraged to read which contained information regarding lessons learnt.
- Staff were aware of the statutory Duty of Candour principles. The department had a system in place to ensure patients were informed and given an apology when something went wrong and were told of any actions taken as a result. The Duty of Candour is a regulatory requirement. The aim of the regulation is to ensure services are open and transparent with people who use services and inform and apologise to them when things go wrong with their care and treatment.

Cleanliness, infection control and hygiene

- In the CQC's 2014 A&E survey, the service scored 8.6 out of 10 for the question: "In your opinion, how clean was the A&E department?" This was about the same as other trusts.
- Medical and nursing staff were observed following the trust policy for hand washing and 'bare below the elbows' guidance in clinical areas. There were hand gel dispensers available in each cubicle and around the department. Hand hygiene was audited on a monthly basis. The audit results for April 2015 showed 100% compliance.
- The emergency department was mostly tidy and we saw cleaning in progress during the visit. However, we saw some dusty equipment and shelving. We also found that inside a cupboard containing medical supplies was dirty. Some cubicle floors were dirty and there were debris on the floors, such as plastic wrappers from medical supplies.
- Protective clothing and equipment such as gloves and aprons was available and used by staff.
- Mattress checks were carried out quarterly. We inspected six mattresses and noted that four of them had holes in the covers and there was evidence of staining on the inside and onto the foam mattress itself. We later observed staff conducting a full audit of the mattresses.
- The majors and minors areas had appropriate facilities for isolating patients with an infectious condition.
- Disposable screening curtains were in use.
- In the children's waiting area, toys were visibly clean; however, this was no clear recorded or monitored cleaning schedule for them.
- The bays had a cleaning checklist in place and we saw these had been completed daily.

- Mandatory training for staff included infection prevention level one and level two. 90% of staff were compliant with level 1 training and 92% of staff were compliant with level 2.The trust target for mandatory training completion was 95% compliance.

Environment and equipment

- The resuscitation room was equipped appropriately. We checked a range of resuscitation equipment and found it accessible and fit for purpose.
- Equipment trolleys were labelled and matched with an equipment checklist.
- There were adequate stocks of equipment and we saw evidence of good stock rotation to ensure that equipment was used before its expiry date.
- Most of the equipment had 'I am clean' labels attached documenting the time and date when it was last cleaned.
- Testing of electrical equipment (portable appliance testing or PAT) had been carried out in the department. However, we found a mobile diagnostic ophthalmoscope which had last been checked in 2013. We were informed by a member of staff that this piece of equipment was no longer in use, however it was easily accessible to staff and could have been used in error.
- All equipment was serviced by the medical engineering department on a rolling programme basis. Stickers on the equipment confirmed servicing and maintenance had been completed.
- Security arrangements were in place 24 hours a day, provided from an external security company. One security guard was based in the emergency department; however they covered the rest of the hospital and walked around the premises. If extra cover was needed within the hospital we were told this was provided by the security company. Closed circuit television (CCTV) was also in operation.

Medicines

- An electronic storage system was used to store and dispense medicines. This was also used to dispense drugs for patients to take home. A member of the pharmacy team restocked this daily and checked the expiry dates of medicines. Access to the system was secure.
- Controlled drugs were stored separately and suitable records were kept in relation to these drugs. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for abuse or addiction.
- We checked a locked cupboard which was used to store intravenous fluids and found the bottom shelf had a collection of different medicines, many of which had been brought in by patients. We were informed these needed to be sent to the pharmacy department for safe disposal. There was no formal system to record when drugs (other than controlled drugs) were brought into the department by patients.
- There was a locked medicine fridge in the minors department. According to trust policy, the temperature of the fridge should have been checked daily. We found 6 days within the last month that this had not been documented. The fridge would alarm if the temperature was outside the recommended range and staff knew what action to take in response.
- We checked the allergy status and found 11 out of the 22 patients notes had no allergy status recorded. This increased the risk that patients might be given inappropriate medicines that could have a harmful effect.

Records

- Patient records were in paper and electronic format. Patients details were recorded onto an electronic system and then a paper copy of the patient notes were printed. We reviewed 22 sets of patient notes and found completion of documentation was variable. For example, nutrition and hydration requirements had only been recorded in four patients' notes, nursing documentation was minimal in all notes and the discharge plan was recorded in two out of 14 sets of notes for patients who went home.
- Pain scores had not been completed in any of the records we reviewed, although some patients told us they had been asked their pain score and had been treated for pain.
- The electronic system alerted staff to any patient specific concerns or risks. For example, if a patient had a previous infection or a safeguarding concern.
- Reception staff collated and filed the patient notes at the end of the visit, generated a GP letter and arranged for safe storage of notes. The notes were stored on site for five months before being archived off site.

Urgent and emergency services

Safeguarding

- The department had systems in place for the identification and management of adults and children at risk of abuse (including domestic violence).
- We reviewed eight children's records. All the children had been assessed regarding safeguarding; however the adults' records did not include an assessment.
- Staff said they knew how to recognise and report both adult and children safeguarding concerns and this reflected what we saw.
- Safeguarding children lead nurses came to the department each day and they had a robust referral system in place. A flow chart was available which informed staff how to manage and refer a concern, for example, a child with a burn or an underage pregnancy.
- The safeguarding children nurse informed us she received a report of all patients under 19 years of age, who attended the department. All these were reviewed daily and any specific alerts and referrals were assessed and reported to the relevant teams if necessary.
- Mandatory training records indicated that 90% of staff were compliant with safeguarding adults level 1 training and 78% of staff were compliant with safeguarding level 2 training. Records also showed that 90% of staff were compliant with safeguarding children level 1 training, 84% were compliant with safeguarding children level 2 training and 22% were compliant with safeguarding children level 3 training. The trust target was for 95% compliance for all mandatory training.

Mandatory training

- Staff completed most mandatory training using e-learning however, there were some clinical skills which resulted in competency based, classroom session's specific to emergency nursing.
- Staff told us time was allocated for mandatory training within the off duty and if the department was quiet they could use the time for training.
- New staff received a corporate induction programme which included some face to face mandatory training.
- Completion of mandatory training for the emergency department was not up to date. The trust's target of 95% mandatory training completion was only met in three out of the 19 areas (resuscitation, moving and handling module A and B). The department averaged an overall completion rate of 76%.

Assessing and responding to patient risk

- Patients who walked into the department were seen by a receptionist and were booked in and directed to a clearly signposted waiting room where they were triaged by a nurse.
- Patients arriving by ambulance were booked in by the ambulance staff at the reception desk before progressing through nurse triage (unless the patient required immediate access to the resuscitation bay).
- The trust used a recognised triage system in the 'minors' area. A modified version of this system was used in the 'majors' area for the initial assessment of all patients. Triage ensures that patients are directed to the appropriate part of the department and the appropriate clinician. It also ensures that serious life-threatening conditions are identified or ruled out so that the appropriate care pathway is selected.
- Guidance issued by the College of Emergency Medicine (CEM) states a face to face assessment should be carried out by a clinician within 15 minutes of arrival or registration. From July 2014 to June 2015, the service's median performance against the 15 minutes standard ranged from 10 and 22 minutes.
- The average time from ambulance to initial assessment was worse than the England average. The department was trialling a new process for ambulance triage, this began in April 2015. Additional staff had been recruited to support the process. As a result, a registered nurse and a clinical support worker triaged the patients who arrived by ambulance. We spoke to ambulance staff and received negative comments regarding the system for example: 'It's confusing', 'It changes daily' and 'There is no triage system'.
- Staff informed us they had plans to visit other hospital emergency departments to observe their ambulance triage processes to enable them to bring back and implement best practice.
- From January 2013 to January 2015, the average time to treatment was in line with the England average and was generally better than the expected standard.
- The national early warning score (NEWS) system was used to identify patients who were becoming unwell. This ensured early, appropriate intervention from skilled staff.
- A handover process to the wards was used known as SBAR. (This is used to describe the patients' medical Situation, Background, Assessment and

Recommendations). This allowed staff to communicate assertively and effectively, ensuring key information was passed to relevant staff and reducing the need for repetition.
- An escalation process was in place which gave staff actions for how to manage if the department during periods of extreme pressure.

Nursing staffing

- The department completed a nurse staffing audit using a recognised workforce planning tool in December 2014. The tool was specifically for use in emergency departments to allow any disparity between nursing workload and staffing to be highlighted. The tool calculated the workforce and skill mix required to provide the nursing care needed in the department during the audit period. The team compared this with the National Institute for Health and Care Excellence draft guideline which advised emergency departments on how to ensure there are safe levels of nursing staff.
- We were told a business case had been developed and wasapproved at the July Board Meeting and funding had been added to the establishment to accommodate this. This business case was as a result of the nurse staffing audit which identified that there was an increased requirement for staff.
- There were 6 registered nurses (RNs) and 2 healthcare assistants (HCAs) on an early shift, 7 RNs and 2 HCAs on a late shift, 5 RNs and 1 HCA on a night shift. In addition, 2 RNs and 1 HCA worked a twilight shift, which was between 5pm and 2am and 1RN and 1 HCA were allocated to do ambulance triage from 10am – 2am.
- In May 2015 nurse staffing had a 13.4% vacancy rate against the budgeted establishment. We were told that nurses had recently been recruited and were awaiting a start date. Staff told us that recruiting nursing staff had not been a problem and the hospital had generic recruitment days which provided a timely recruitment process.
- Agency nurses were used to cover sickness and vacancies; these were nurses who were experienced in working in emergency medicine. In May 2015, 6.5% whole time equivalent nursing shifts in the emergency department had been covered by agency staff. Agency staff received an induction before commencing work in the department. Occasionally nurses from the intensive care unit or a healthcare assistant from one of the wards would provide cover if they were available.
- The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) identifies that there should always be a registered children's nurse in the emergency department, or trusts should be working towards this. From September 2014, a paediatric nurse was on duty between 9am and 10pm, 7 days per week. During the hours the paediatric nurse was not on duty, support was provided as needed from the paediatric department.

Medical staffing

- The consultant baseline staffing in the emergency department was five consultants, but the trust planned to increase this number to eight.
- At the time of our inspection there were three substantive consultants (of whom one was leaving in mid-August) and three locum consultant staff. A further three staff had been appointed to vacant posts, who would work as Associate Specialists until they had been successful in getting accreditation.
- The three doctors appointed as Associate Specialists would commence as soon as checks and clearances were complete, one of these was an international candidate currently awaiting GMC registration. In the interim this post was being covered by a middle grade doctor and a locum.
- To achieve the new baseline of eight consultants, there were still three full time vacancies. These vacancies were being advertised at the time of the inspection. Recruitment to consultant posts in the emergency department had been difficult. As a result, the trust was looking at new ways to promote the service and create interest, for example a video of the department was being developed which was to be included in promotional material.
- There were 6.6 whole time equivalent (WTE) middle grade doctors (against a planned 8 WTE posts) and 6.6 WTE junior doctors (against a planned 6 WTE posts).
- Consultant rotas demonstrated that a consultant was present in the department Monday to Friday between 8am and 11pm and at weekends between 8am and

5pm. Consultants provided on call cover 24 hours a day, seven days a week. A middle grade doctor was also present in the department 24 hours each day, seven days per week.

Major incident awareness and training

- Two staff members were link nurses for emergency planning, they were responsible for ensuring training was up to date and that adequate stores and equipment was available and checked regularly.
- There were designated store rooms for major incident equipment. Staff were unable to unlock one of the cupboards, they assured us this would be reported and fixed.
- Staff received annual major incident training and two years ago staff had attended a full multidisciplinary team exercise with other outside agencies. Table top exercises were also conducted.
- Staff could describe processes and triggers for escalation. They described to us the arrangements to deal with casualties contaminated with hazardous materials (HAZMAT) such as chemical, biological or radiological materials.
- We found the HAZMAT protective suits had an expiry date of May/June 2015. We raised this with staff who checked with the company who supplied the suits; we were informed they were safe to use and new suits had been ordered.
- Staff had received training on how to care for someone who may have symptoms of Ebola.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

There were a range of pathways that complied with the National Institute for Health and Care Excellence (NICE) guidelines and the College of Emergency Medicine's (CEM) clinical standards for emergency departments. From January 2013 to January 2015, the unplanned re-attendance rate to the emergency department within seven days of discharge was consistently better than the England average. There was evidence of multidisciplinary working. Clinical nurse specialists came to the department to provide clinical expertise and review patients. However, access to mental health services was not timely and this was a concern to staff. We were told there were plans in place to try and address this issue.

The department had achieved mixed outcomes in the College of Emergency Medicine (CEM) audits on severe sepsis and septic shock and assessing cognitive impairment in older people with some areas performing worse than the national average. Action plans were in place to address the areas for improvement. Appropriate pain relief was offered to patients however pain scores were not routinely recorded.

Staff felt supported by their managers and there were appraisal systems in place. 75% of nursing staff had received an appraisal in the last 12 months. All medical staff were up to date with their appraisals. Staff understood the requirements of the Mental Capacity Act 2005.

Evidence-based care and treatment

- There were a range of pathways that complied with the National Institute for Health and Care Excellence (NICE) guidelines and the College of Emergency Medicine's (CEM) clinical standards for emergency departments.
- The trust participated in the national CEM audits so it could benchmark its practice against other emergency departments.
- We spoke to the stroke clinical nurse specialist who explained the pathway for patients who attended the department with a suspected stroke. The clinical nurse specialist covered the department between 8am and 4pm seven days a week. There was cover from a medical consultant who specialised in the care of patients who have had a stroke 24 hours, seven days a week.
- Out of core working hours the specialist was consulted via a 'tele stroke' service video linked to the department. The consultant viewed CT scans and investigations and provided specialist advice to doctors within the emergency department if needed.
- We reviewed the notes of two patients who had been admitted following a fractured neck of femur. Both patients were on the pathway, however, the completion of documentation was inconsistent. A member of staff on the orthopaedic ward informed us that patients did not always receive the necessary treatment in the emergency department, such as having intravenous fluids, pain relief or a femoral block.

Urgent and emergency services

Pain relief

- We reviewed 22 patients' notes and we found none had a pain score documented. However, we did find evidence that pain relief was given from their prescription charts.
- In the CQC's 2014 A&E survey, the trust scored 7.5 out of 10 for the question: "Do you think the hospital staff did everything they could to help control your pain?" However, they only scored 6.4 out of 10 for the question: "How many minutes after you requested pain relief did it take before you got it?" Both scores were about the same as for other trusts.
- Patients told us they were asked if they required pain relief.

Nutrition and hydration

- We noted that staff rarely recorded in the patients' records whether food and drink had been offered to patients.
- Patients were offered hot and cold drinks. A snack box was available which contained a sandwich and fruit. Yogurts and bread with butter and jams were also available. A healthcare support worker would ask patients if they required food or drink. Patients who were in the department for a long time could have a hot meal if they wished.
- In the waiting room there were vending machines which contained cold and hot drinks, chocolate and crisps.
- There was a notice on the wall to inform patients to ask staff if they could eat, however, this message was displayed amongst other information and could easily be missed.
- Baby food was accessed from the children's ward if needed.

Patient outcomes

- From January 2013 to January 2015 the unplanned re-attendance rate to the emergency department within seven days of discharge was consistently better than the England average but worse than the standard of 5%.
- The department had achieved mixed outcomes in the CEM 2014 audits on severe sepsis and septic shock and assessing cognitive impairment in older people.
- The sepsis audit found that an average of 94% of patients received antibiotics within the four hour recommended timeframe. However 32% of patients' received antibiotics within one hour of arrival to the emergency department against a national average of 50%. There was evidence that urine output measurements were instituted in the department for only 38% of patients.
- The audit for assessing cognitive impairment in older people 2014-2015 also found mixed results. The service performed better than the national average for standard 6: Early Warning Score documented (93% compared to the national average of 82%). However, the trust fell below the national average for standard 5: Recording cognitive assessment score and standard 3: Admitting service (for inpatients only).
- Action plans had been developed in relation to these audits but the actions required, particularly in response to the assessing cognitive impairment audit, were not always specific. For example one action stated: 'Short cognitive assessment should be done in the triage of all patients > 75 yr. age'. However, it wasn't clear what action would be taken to ensure this was achieved. Each action had clearly been allocated to an individual and there was a timescale for completion. The service planned to undertake a re-audit to determine whether improvements had been made.

Competent staff

- Appraisals were undertaken with both medical and nursing staff and staff spoke positively about the process.
- 75% of nursing staff (band 1-7) had received an appraisal in the last 12 months. This was below the trust target of 90%. All medical staff however, were up to date with their appraisals.
- Staff completed a learning and development document which was completed as part of the annual appraisal in order to identify and plan learning and training needs.
- The 2014 staff survey indicated 81% of staff in the department felt their manager supported them to receive training, learning and development.
- New nursing staff received emergency department specific competency based training. They were supported by a mentor and were supernumerary for a period of time which varied depending on their previous experience and learning needs.
- Consultants received training in paediatric life support and additional support could also be provided by a paediatrician from the children's ward if required.

Multidisciplinary working

- Clinical nurse specialists came to the department to provide clinical expertise and review patients. For example, we observed the stroke clinical nurse specialist within the department.
- The department had forged improved links with social care multi-disciplinary teams within the neighbouring communities which had supported safe discharge of patients with complex social needs.
- Occupational therapy staff helped assess patients' suitability for discharge within the department.
- A new nursing post had been introduced which meant that a nurse saw patients who attended frequently. The nurse liaised with the patient's GP and other services to support the patient at home to avoid hospital admission.
- There were alcohol liaison workers who supported patients with alcohol misuse issues. They visited the department Monday to Friday between 9am and 5pm. Out of hours a referral form was completed.
- GPs worked within the department between 8am and 6pm, Monday to Friday. They saw patients who presented with complaints which could be dealt with within a GP practice rather than in the emergency department. The aim of this service was to reduce pressure on the emergency department staff and to ensure patients were seen in a timely way.
- Staff told us access to mental health services was not timely. There was a mental health liaison service which was hospital based and could be accessed Monday to Friday between 8am and 6pm, and Saturday and Sunday, 10am to 6pm. Out of hours mental health cover was from the crisis team only, which was a community based service and meant patients waited in the emergency department a long time before they were being seen. We were told there were plans within the 'Better care together' project and 'front door project' to improve access to mental health services.

Seven-day services

- Access to radiology services was available 24hours a day, seven days a week.
- Consultants provide on call cover for 24 hours, seven days a week. A middle grade doctor was also present in the department 24 hours each day, seven days per week.

Access to information

- Medical and nursing staff could access current and past information for each patient in the department displayed on an IT system. The status of the trust's two emergency departments (Royal Lancaster Infirmary and Furness General Hospital) could be viewed on either site, thus enabling an overview of the demands on each service and effective use of resources.
- Patients' previous medical notes were held on site for five months before being archived off site. If required they could be requested and staff told us they were accessible.
- Staff had access to relevant guidance and policies via the trust's intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Doctors and nurse obtained verbal consent from patients before providing care and treatment where possible. We heard staff explaining treatments and diagnoses to patients, checking their understanding, and asking permission to undertake examination and perform tests.
- Training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was included within the mandatory safeguarding training. We were told there was also a consultant lead for this area.
- Staff were clear about their responsibilities in gaining consent from people including those who lacked capacity to provide informed consent to care and treatment.
- Staff used Gillick competency principles when assessing capacity and obtaining consent from children. The 'Gillick Test' helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. They must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of actions.

Urgent and emergency services

Are urgent and emergency services caring?

Good

The emergency department provided a caring and compassionate service. We observed staff treating patients with dignity and respect. Patients told us staff were caring, attentive and helpful and kept them well informed.

Responses to the family and friends test indicated that the majority of patients would recommend the service to family or friends. Patients told us staff ensured they understood medical terminology and patients were given literature about their condition when required.

Compassionate care

- The response rate for the Friends and Family Test in March 2015 was 29.1% of which 87% of patients stated they would recommend the service to family and friends and 7% would not recommend to family and friends. In April and May 2015 the response rate was 30% with 91% stating they would recommend the service to family and friends and 3% stating they would not recommend the service.
- In the CQC's 2014 A&E survey, the trust scored the same as other trusts in all 24 questions relating to caring with an overall score of 7.8 out of 10.
- During our inspection we observed staff treating patients with dignity and respect. Patients were complementary of the staff. One patient described staff as: "kind and patient, and they made sure I understood medical terms". Another patient commented that they felt safe and their dignity had been respected.

Understanding and involvement of patients and those close to them

- Patients told us staff ensured they understood medical terminology and patients were given literature about their condition when required.
- A range of information leaflets were available for patients to help them manage their condition after discharge however, leaflets were available in English only. Staff told us they were able to access and interpreter service I required for patients whose first language was not English.
- One patient told us she was not able to eat or drink but her carer had been offered two drinks whilst she had been in the department and staff had given her and her carer good support and kept them well informed.
- We observed that patients were given a clear explanation at discharge and were advised what to do if symptoms re-occurred.

Emotional support

- There was a room for relatives to use if they needed with access to a telephone and drinks.
- We observed staff offering emotional support to patients who were anxious. They spent time reassuring them and explaining what was happening and why.
- There was support available for the bereaved from the chaplaincy and the bereavement office.

Are urgent and emergency services responsive to people's needs? (for example, to feedback?)

Requires improvement

From April 2014 to April 2015 the trust had struggled to meet the Department of Health four hour access target. Data for this period showed the hospital had only achieved the 95% standard for 14 out of 52 weeks. However, there had been some improvement from 1 April 2015 to 5 July 2015 when the department's performance against the four hour standard was 96.2%. Royal Lancaster Infirmary had experienced 674 black breaches from March 2014 to March 2015, whereby the time from an ambulance's arrival to the patient being formally handed over to the department was longer than 60 minutes.

In order to manage the changing demands in health and social care, the trust was working collaboratively with GPs and community services to try and reduce the number of patients needing to attend hospital. The department was accessible for people with limited mobility and people who used a wheelchair. There were systems in place to support people living with dementia however; staff told us they had received little guidance on how to support

patients with a learning disability. Learning from complaints was discussed in the monthly governance meeting and during handover. An information board in the staff room also displayed lessons learnt information.

Service planning and delivery to meet the needs of local people

- In order to manage the changing demands in health and social care, the trust was working on a strategy called 'Better Care Together' which outlined new plans of delivering health care. The strategy aimed to reduce the number of patients needing to attend hospital, by working collaboratively with GPs and community services.
- During our visit the department was not overcrowded and a sufficient number of treatment rooms and cubicles were available, although at times of peak demand staff informed us ambulances did sometimes queue in the department.
- Within the waiting room there were a number of notice boards. One was a 'how are we doing' board. This had information regarding action taken by the service in response to patient feedback using a 'what you said and what we did' format. There was a patient and visitor's information board and a 'welcome to the emergency department' board that provided key useful information to patients and visitors about the service.
- There was an ambulance triage room that was also used as a viewing room for deceased patients. (In such instances an alternative room was used for ambulance triage). We were advised that it would also serve as a decontamination room in the event of a patient having had contact with hazardous material. When in use as a viewing room for deceased patients, the environment was clinical without any comforting features that may help relatives and friends during such a difficult time.
- A parent commented that the children's waiting room was too small and cramped.

Meeting people's individual needs

- The department was accessible for people with limited mobility and people who used a wheelchair. Wheelchairs were available in the department if required.
- There was access to a motorised bariatric trolley and a bariatric bed could be made available on a ward if needed. Bariatrics is the branch of medicine that deals with the causes, prevention, and treatment of obesity.
- There was a cubicle used for patients living with dementia. This was painted a different colour to the other cubicles and a picture was on the wall to help the patient recognise it. There was also a clock on the wall with clear numbers to help patients distinguish between night and day. These changes are aimed at reducing anxiety.
- A member of staff showed us a box containing reminiscent objects such as a ration book and old pictures. This was used to reduce patients' anxieties of being in an unfamiliar place. The staff member told us it was a helpful tool and many patients enjoyed looking through the items.
- A nursing post had recently been introduced which supported patients who attended the department on a frequent basis. The nurse liaised with the patients' GP and other necessary teams to support the patient at home and avoid the need for frequent attendances to the department
- We were informed there were several link nurses who provided up to date expertise on various topics to support the team such as diabetes and respiratory conditions.
- Within the paediatric department there was access to a play specialist, who provided distraction when children underwent medical procedures. They also accompanied children to other departments for investigations and procedures.
- Staff told us they did not have any specific guidance to assist them on how to support patients with a learning disability. They told us they would encourage their carer to stay with the patient to help alleviate any anxieties the patient may have.
- A range of information leaflets were available for patients to help them manage their condition after discharge however, leaflets were available in English only.

Access and flow

- The Department of Health target for emergency departments is to admit, transfer or discharge patients within four hours of arrival. From April 2014 to April 2015, the trust struggled to meet this target. From November 2014 onwards the trust had performed better than the England average but was still not meeting the target.
- Data showed that from April 2014 to April 2015 Lancaster Royal Infirmary achieved the 95% standard for 14 out of 52 weeks.

Urgent and emergency services

- For 2014/15 the trust did not meet the standard for quarter one and quarter two, (achieving 92% overall). The trust met the standard for quarter three, achieving 95%. However, the trust failed to meet the standard again in quarter four achieving 92%.
- However, there had been some improvement from 1 April 2015 to 5 July 2015 when the department's performance against the four hour standard was 96.2%.
- From 6 April 2014 to 29 March 2015, the percentage of emergency admissions waiting four to 12 hours from decision to admit until being admitted was better than the England average.
- The percentage of patients leaving before being seen was worse than the England average, apart from July 2014 and January 2015 where the trust performed better than the England average.
- From January 2013 to January 2015, the total time patients spent in the emergency department (average per patient) was generally worse than the England average.
- Royal Lancaster Infirmary had experienced 674 black breaches from March 2014 to March 2015. Black breaches occur when the time from an ambulance's arrival to the patient being formally handed over to the department is longer than 60 minutes. The hospital was trialling a new ambulance triage system to try and improve this but had not received positive feedback from ambulance staff. Staff informed us they had plans to visit other hospital emergency departments to observe their ambulance triage processes to enable them to implement best practice.
- During the inspection we observed flow of patients and reviewed current information on waiting times. We spoke to six patients in the waiting room who had been waiting up to 45 minutes. Four patients had been seen by a triage nurse within 50 minutes. The majority of the patients were not aware of the expected waiting times. One information board stated the waiting time was 2 hours and another said it was 2.5 hours.
- We reviewed the notes for 16 patients who had arrived by ambulance. Time to initial assessment was between 0 and 34 minutes, the average time being 26 minutes.
- We observed the flow of children who had attended the department through the 'minors' stream. We spoke to the parents of a child who was seen immediately by the children's nurse. We reviewed four children's notes which showed they were assessed within 4 to 26 minutes.
- We were told the timeliness of patients been transferred to a ward had improved due to a patient flow meeting which had been reviewed and improved since October/ November 2014. A patient flow meeting took place at least three times a day with an escalation plan in place to increase to four times a day if necessary. The meetings included representation from senior managers within each speciality, the discharge planner, radiographer, transport liaison, bed management team and the coordinator from the emergency department.
- This meeting also linked with Furness General Hospital via teleconference. The emergency department coordinator could discuss issues at the meeting which were preventing patient flow through the department. This meant appropriate action could be taken to expedite the transfer of the patient to the correct ward.

Learning from complaints and concerns

- There were 28 complaints made between 1 June 2014 and 31 May 2015. The majority of these were related to staff attitude. We were unable to establish if any specific training had been given to staff as a result of this.
- Staff told us they were aware of how to deal with complaints. We were told doctors would look at the complaints which involved medical staff or medical care and the unit manager would look at the complaints which involved the nursing staff or nursing care. The complaints department team produced a draft letter to the complainant and this was checked by the person investigating the complaint.
- Feedback was given to staff face to face or by email. Any lessons learnt were discussed in the monthly governance meeting and during handover. An information board in the staff room also displayed lessons learnt information.

Urgent and emergency services

Are urgent and emergency services well-led?

Good

Monthly governance meetings were held, attended by the clinical director, management and senior nursing staff. Staff were motivated and described a supportive team-working environment. The environment was described as non-hierarchical and staff felt that each member of the team was appreciated. The trust had run engagement events and workshops around the development of their vision and values. However, none of the staff we spoke with felt they had been actively engaged or that their views were reflected in the planning and delivery of services. The trust's "Acute and Emergency Medicine Division Staff Survey & Pulse Survey Action Plan 2015-16" identified key areas for improvement including staff motivation and engagement. The action plan had clearly defined actions that had been allocated to members of staff with timescales for completion.

None of the staff we spoke with could articulate the current strategy and vision for the service. The department had a risk register, which identified risks and control measures to mitigate these. Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history.

There was little evidence of innovation and cross – departmental working with the emergency department at Furness General Hospital. This could result in the department working in isolation and opportunities to share education, lessons learnt and good practice may be lost.

Vision and strategy for this service

- None of the staff we spoke with could articulate the current strategy and vision for the service.
- However, the trust was working on a strategy called 'Better Care Together' which outlined new plans of delivering health care. The strategy aimed to reduce the number of patients needing to attend hospital, by working collaboratively with GPs and community services.

Governance, risk management and quality measurement

- The department was part of the Acute and Emergency Medicine division. Each clinical division was headed by a clinical director, supported by a divisional general manager and an assistant chief nurse. A governance lead was also allocated to each division.
- Monthly governance meetings were held, attended by the clinical director, management and senior nursing staff. Items covered included workforce, risks, health and safety, effectiveness, complaints and lessons learnt.
- The emergency department had a service risk register. The department had a risk register, which identified risks and control measures to mitigate these. Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history.
- The main risks on the risk register were associated with low staffing levels, which could result in failure to deliver high quality, safe and effective care, including a delay in patient assessments and observations not being recorded. The risk register was completed and managed by the matron.
- We were told that work had been undertaken regarding workforce efficiency and development days for nurses had been introduced by the senior nursing team, in which information and learning was cascaded.

Leadership of service

- Staff were motivated and described a supportive team-working environment. A student nurse told us: 'It's a good learning environment, staff are always helpful and supportive, I never have concerns regarding asking for help and the placement has been a positive, enthusiastic experience.'
- Staff told us they had good support from their matron and the business manager; both were visible in the department. We were told there had been a recent positive change in the management structure.

Culture within the service

Urgent and emergency services

- Staff described the culture within the service as a supportive, friendly environment to work in. The environment was described as non-hierarchical and staff felt that each member of the team was appreciated.
- The service had a 23.5% nursing turnover rate and a 38.7% medical staff turnover rate.
- In the staff survey dated July 2015, 90% of staff in the acute and emergency medicine directorate said the organisation encouraged them to report errors, near misses or incidents.
- The trust's "Acute and Emergency Medicine Division Staff Survey & Pulse Survey Action Plan 2015-16" identified three key areas for improvement: Staff motivation and engagement, lessons learnt and feedback to staff from reporting of clinical incidents, staff to be appropriately trained and skilled. The action plan had clearly defined actions that had been allocated to members of staff with timescales for completion.

Public and staff engagement

- The trust had run engagement events and workshops around the development of their vision and values. However, none of the staff we spoke with felt they had been actively engaged or that their views were reflected in the planning and delivery of services. The trust had recognised this as an area for improvement and an action plan was in place.

Innovation, improvement and sustainability

- There was little evidence of innovation and cross – departmental working with the emergency department at Furness General Hospital. This could result in the department working in isolation and opportunities to share education, lessons learnt and good practice may be lost.

Medical care (including older people's care)

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

We visited Royal Lancaster Infirmary as part of our announced inspection on 15 July 2015 and again as part of unannounced inspection on 29 July 2015 in the evening.

The medical care services at the hospital provided care and treatment for a wide range of medical conditions, including general medicine, cardiology, respiratory, and gastroenterology.

During the inspection we visited wards 20 and 21 (elderly care), ward 23(stroke unit), ward 37(respiratory care), ward 39 (stroke, gastroenterology, oncology and cardiology care) and the acute medical unit (AMU). We reviewed the environment and staffing levels and looked at 43 care records. We spoke with 10 family members, 11 patients and 40 staff of different grades, including nurses, doctors, ward managers, matrons, a domestic assistant and the leads for medical services.

We received comments from people who contacted us to tell us about their experience, and we reviewed performance information about the trust. We observed how care and treatment was provided.

Summary of findings

Following our inspection in 2014 we rated the hospital as inadequate for medical care. As part of that inspection we identified that staffing levels, skill mix, systems and processes all required improvement to secure and maintain the safety and effectiveness of the service. There were particular concerns about nurse staffing levels and skill mix on Ward 39. The quality of nursing records required improvement and some patient records and risk assessments were incomplete. Wards and departments were not always well-led at a senior level and there was a disconnect between the staff providing care and the executive team.

We found that although significant changes had been made to improve the medical care services, further improvement was still required. Staffing establishments had improved however on some wards, nurse staffing remained a challenge. Staff recruitment was in progress to fill staff vacancies but there were still medical staffing vacancies in some specialities. Safety data indicated that there were a high number of falls but it was not clear what action had been taken as a result. Nurse record keeping had improved but completion of care records was still variable and recording of fluid balance charts was inconsistent. Medical decisions were not always recorded in patient notes and some medical entries in patient records were illegible. There were systems in place to support people living with dementia however; staff told us that there had been difficulties in accessing mental health services. We found that staff

Medical care (including older people's care)

members' understanding and awareness of the need to assess people's capacity to make decisions about their care and treatment were variable. Staff did not always follow capacity assessment processes in line with trust policy.

Recent national audits indicated that although there had been progress, the service still needed to make improvements to the care and treatment of people who had suffered a stroke. Most staff said they were supported effectively but the appraisal completion rate was below the trust target of 90%. The bed occupancy rate for the hospital had been consistently above 90% over the six months prior to inspection. There were a number of patients who experienced multiple ward moves during their stay. There were also a high number of patients placed on wards that were not best suited to meet their needs (medical outliers). Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history.

Divisional governance board meetings were held on a monthly basis. Minutes from the meetings showed that a monthly report, which included risk registers, mortality incidents, audits and safety alerts, was discussed at the meeting. However, it was not always clear how the learning was then cascaded to ward staff or whether it had already been shared.

The visibility of senior management had improved since the last inspection. The trust was working in partnership with other organisations to help meet the needs of people. Staff were committed and passionate about providing good quality care. Patients told us staff were caring, kind and respected their wishes. We saw staff interactions with people were person-centred.

Are medical care services safe?

Requires improvement

As part of the last inspection we found skill mix and staffing levels required improvement. There were particular concerns about nurse staffing levels and skill mix on Ward 39. We found that although significant changes had been made to improve medical services on the wards, further improvement was still required. The quality of nursing records had improved but still required improvement as some patient records and risk assessments were incomplete.

Staffing establishments had improved since the last inspection however on some wards nurse staffing remained a challenge. Ward 39 had 5.2 registered nurse vacancies with two new starters commencing in September 2015. Senior staff said that the staffing establishment on the ward was unsustainable for the number of beds (50 beds) as they had been asked to reduce the number of clinical support workers. They were unsure how the new staffing figures for clinical support workers had been decided as they had not been involved in the review. A review of staffing over a one month period showed that the skill mix on ward 39 did not always fall in line with the trust's 'red rules' initiative. There was a lack of consultants in some specialist services though the trust told us that there is a recruitment programme in place. Over the past 6 months the locum cover had been as high as 51.5%. The specialities that had high use of locum cover included elderly care, diabetes, dermatology and services. Mandatory training completion levels varied, with some falling below the trust target.

We found that there were systems in place for reporting, investigating and learning from incidents. However, safety data regarding harm free care was collated on a monthly basis and showed that from January to June 2015 there had been a high number of falls. The high number of falls had been on the risk register since 2012. Medication charts were fully completed and controlled drugs were stored and administered appropriately. However, we found instances when other prescribed medication had not been stored or administered safely and in line with best practice.

Medical care (including older people's care)

Completion of care records was still variable and recording of fluid balance charts was inconsistent. Medical decisions were not always recorded in patient notes and some medical entries in patient records were illegible.

Incidents

- Staff were familiar with and were encouraged to use the trust's procedures for reporting incidents. They understood their responsibilities to raise concerns and record safety incidents.
- Between April 2014 and March 2015 the trust reported 1378 incidents. This was an increase from the previous year. Between January 2015 and June 2015 the medical care services reported 1984 incidents of which 1253 were either a near miss or resulted in no injury or harm. The trust was in the top 25% of incident reporters which showed a positive culture towards reporting of incidents.
- From May 2014 to April 2015, data showed there had been 20 serious incidents reported by the medical care services. All serious incidents were subject to a full root cause analysis investigation and action plans were developed where areas for improvement had been identified. 24 staff from different professions such as nurses, senior staff and practice educators had completed investigating incidents training.
- There were systems to support shared learning from incidents across medical wards.
- A monthly newsletter, which outlined lessons learnt from incidents, was displayed on the staff noticeboard.
- Senior staff told us general feedback on patient safety information was discussed at ward staff meetings or in staff huddles. On the majority of wards, senior staff facilitated time with ward staff to look at lessons learnt from incidents.
- The workforce, efficiency, safety, effectiveness and experience (WESEE) report highlighted incidents and risks. This report was produced by the ward managers on a monthly basis and was discussed with staff on the wards and with the matrons. The WESEE reports on ward 39 identified the incidents and learning to be shared with staff. However, there were no other meeting minutes for ward 39 which showed actions to be taken to improve performance and learn from incidents. The ward meeting minutes for the other wards that we visited showed clear actions and the member of staff responsible for the implementation of the action. These included learning from incidents.
- Staff were able to describe the last incident on the ward and the lessons learnt. An example of this was that following a serious incident there had been a review of staffing levels and these had been improved. Examples were given of key themes that had emerged from recent incidents of falls and pressure ulcers.
- Following incidents, ward staff told us they received feedback from the person reviewing the incident via the computerised system. This included lessons learnt and any actions taken. Most staff told us they received feedback but some staff did not know the outcome of incidents that were reported.
- Since the duty of candour regulations were introduced in 2014, an audit of compliance had been carried out by the trust. During the period April 2015 to June 2015, we saw evidence that people had been appropriately informed of an incident in line with duty of candour principles and the actions that had been taken to prevent recurrence. The aim of the duty of candour regulation is to ensure trusts are open and transparent with people who use services and inform and apologise to them when things go wrong with their care and treatment.
- Mortality and morbidity meetings were held weekly or monthly and were attended by representatives from teams within the relevant divisions. As part of these meetings, attendees reviewed the notes for patients who had died in the hospital within the previous week. Any learning identified was shared and applied

Safety thermometer

- The NHS safety thermometer is a national improvement tool for measuring, monitoring and analysing harm to people and 'harm free' care. Monthly data was collected on pressure ulcers, falls, catheter acquired urinary tract infections (CAUTI) and blood clots (venous thromboembolism or VTE).
- Staff confirmed the safety thermometer was undertaken once a month. A ward manager told us that they did not receive feedback on the findings although they were aware of changes in practice that had taken place as a result of a recent audit.
- From March 2014 to March 2015, 99 pressure ulcers were reported, including six grade 3 hospital acquired pressure ulcers. 23 falls with harm and 54 CAUTIs were also reported during this period. The number of pressure ulcers, falls and CAUTI's remained relatively

consistent throughout this period. There was a small rise in the number of CAUTIs between August 2014 and October 2014 but these had since dropped to a more consistent rate.

- Between January 2015 and June 2015 a total of 634 incidents were recorded as falls of which ward 39 had 110 which equated to 17.4% of all falls in the trust. Ward 39 had the highest number of reported falls. The trust told us that 89 of these falls resulted in no injuries. The high number of falls had been on the medical services risk register since 2012 with a moderate risk rating. The high number of falls on Ward 39 had been on the risk register, with a moderate risk rating, since 2013.

Cleanliness, infection control and hygiene

- The wards and communal areas we visited were visibly clean and free from odours. Personal protective equipment was available for staff to use. All wards had antibacterial gel dispensers at the entrances and by people's bedside area.
- All wards we visited had facilities for isolating patients identified as an increased infection control risk.
- Cleaning schedules had been completed as required. Domestic staff told us there were sufficient supplies of cleaning materials available for their use. They were able to tell us about the national colour coding scheme for hospital cleaning materials and equipment. This ensured that these items were not used in multiple areas, therefore reducing the risk of cross infection.
- Staff followed good practice guidance in relation to the control and prevention of infection in line with trust policies and procedures.
- This included the use of 'I am clean' stickers to inform colleagues at a glance that equipment or furniture had been cleaned and was ready for use.
- Toilets were visibly clean and had appropriate hand washing facilities. Cleaning schedules had been signed and dated to say that they had been checked regularly.
- On Ward 39 if the housekeeper was not on duty, there were specific cleaning duties for staff to undertake, such as bedside cleaning. However, there was nothing in place to ensure that this had been done.
- In the clinic room on Ward 20 sharp bins, which were used to store used needles, were overflowing. Best practice states that sharps bins should not be more than two thirds full and should never be overfilled to reduce the risk of sustaining a sharp injury. Sharp bins are marked with a line that indicates when the container should be considered full.
- Between December 2014 and June 2015 there had been one case of MRSA. Between December 2014 and June 2015 there had been six cases of Clostridium difficile reported in the medical division at the hospital. Four of these were avoidable. Meetings had taken place regarding these incidents which included looking at lessons learnt.

Environment and equipment

- The environment was clean and tidy and the décor was well maintained. Clinical areas were well maintained.
- There were systems in place to maintain and service equipment. Portable appliance testing had been carried out on electrical equipment regularly and electrical safety certificates were in date. Hoists had been serviced appropriately.
- Resuscitation equipment was available on all the wards we visited and tamper seals were in place. Emergency drugs were available and within the use by date.
- The door on the dirty utility room in the acute medical unit (AMU) was left open and bottles of cleaning chemicals were left on the floor. Cleaning chemicals were also left in an unlocked area on Ward 20. These chemicals were hazardous and presented a risk of harm to people's health as a result they should have been stored securely in line with regulatory requirements.
- On ward 23 portable oxygen cylinders were kept in the central communal area of the ward and were not stored in a locked room. Health and safety best practice guidance is that oxygen cylinders should be stored securely in a well ventilated storage area or compound when not in use.
- On ward 20 the assisted bathroom entrance was blocked by chairs which made it difficult for patient and staff to access it.

Medicines

- Medication charts were fully completed and there was no evidence of excessive prescribing of sedative medicines on the wards we visited.
- One patient on ward 39 had been admitted late in the afternoon before our visit. After review by the pharmacist they were still waiting for medication to be

delivered on the morning of the inspection. The medication prescribed was to be given that morning. Staff confirmed that it would be given as soon as the medication had been delivered.

- The pharmacy team had access to the wider GP's prescription record, including dose and frequency of administration but other staff, who were prescribing medication on admission, had more limited information. It had been highlighted as a risk by pharmacy that staff may not have the necessary information to ensure the correct prescribing of medication that patients were already taking. To mitigate the risk, pharmacists printed off information so that it was available to prescribers.
- There was an electronic system available on all of the wards we visited. The system gave clear information around the number of patients that had received medicines reconciliation together with the request and availability of medicines for patients who were being discharged.
- Controlled drugs were stored securely and access was limited to qualified staff employed by the trust. Registers were completed in line with trust procedures. Two nurses were observed following the correct procedures for the administration of controlled drugs for a patient.
- Medicines requiring storage at temperatures below eight degrees centigrade were appropriately stored in fridges. Daily temperature checklists were consistently completed.
- On one ward fridge temperatures had been recorded that were outside the recommended range of between 2 and 8 degrees. The nurse we spoke with had not been showed how to check that the fridge was set for the correct temperature. Any change in temperature out of the recommended range could potentially affect any medications in the fridge making them unfit for use.
- There were intravenous fluids that were out of date on Ward 39, Ward 37 and the AMU. There was no system in place to monitor the expiry dates of these products and they would only be picked up at the time of selection for the patient. There was a risk that there would only be out of date IV fluids available and/or that expired fluids may be given in error.
- On ward 39 there was opened and in-use insulin stored at room temperature which had been left out for longer than the recommended 28 days. Staff confirmed that nobody had been administered the medication that day and these were disposed of.
- We observed that a patient was administering his own insulin on the AMU. The insulin pen was left lying on the top of their locker alongside a pot of pen needles. There was nothing on the patient's chart to indicate that this person was administering their own insulin and there was no lockable facility by the bedside. The patient said that staff disposed of the used needles.
- On ward 39 at 10.00 a.m. we observed that patient medication had been left on the table from the morning medication round. Staff were alerted to this and they then ensured that the patient took their medication.
- On ward 39 staff reported they had had difficulties in administering antibiotics on time due to workload. If antibiotics are not given at the correct times it can impact on how effective they are.
- 'Staff not following medication policies' on Ward 39 had been put on the medical services risk register in 2012 with a moderate risk rating. The trust told us that actions had been identified.

Records

- During the inspection we reviewed 43 care records. The hospital used paper-based and electronic records. Patient records included a range of risk assessments and care plans that were completed on admission and were updated throughout a patient's stay. However, we found these documents were not completed consistently across all the wards we visited.
- We looked at the documentation kept to record people's vital signs, fluid balance and food intake. Recording of fluid balance charts was inconsistent. For example, on ward 39 out of eight fluid balance charts reviewed, four were not fully completed and did not record the running totals. On Ward 20 there was information about a different patient in one of the records we looked at.
- Medical decisions were not always fully documented. On ward 39 a patient's notes stated that medication was withheld but the reason why was not clearly documented.
- On Ward 39 there were two records where doctors had not written in the notes after seeing the patient. Staff told us they were chasing the doctors to complete the entries.

- Some doctor's entries were illegible though generally nursing entries were legible, dated and signed.
- Wards had lockable patient note trolleys. On ward 39 we observed some of these trolleys were left open and unattended in the corridors.
- The electronic patient boards that were visible in ward corridors respected patient confidentiality by using codes instead of patient names. Electronic patient boards were used to provide an at a glance overview of the key risks, medication and discharge plans for each patient.

Safeguarding

- Safeguarding policies and procedures were in place and staff knew how to refer a safeguarding issue to protect adults and children from abuse.
- The trust compliance target for safeguarding training was 95%. In medical care services, 85% of staff had completed safeguarding adults level1 training and 90% had completed level 2 training. For safeguarding children training the compliance rate for Level 1 training was 85% and for level 2 training was 90%. However, from the information provided by the trust at the time of the inspection, the compliance rate for level 3 safeguarding children training was only 29%
- Data suggested that staff were raising safeguarding concerns appropriately in line with the trust's policies and procedures. 326 referrals were made to the adult safeguarding team between July 2014 and July 2015. This was 35% of the total number of patient safety incidents reported during the last 12 months.

Mandatory training

- Staff received mandatory training on a rolling annual programme which was mainly available on the internet. The band 6 nurse in the nursing team was responsible for ensuring that staff were up to date with their training.
- The trust compliance target for mandatory training was 95%. This was being met for some of the topics; however it was below the target for conflict resolution at 65%, fire safety at 68% and some moving and handling modules which were between 52% and 58%.
- Senior staff reported that on ward 39 the compliance rate for conflict resolution training was low. The ward manager outlined the actions in place to increase compliance.

Assessing and responding to patient risk

- The trust had its own early warning trigger system in place called the Physiological Observation Track and Trigger System (POTTS). This was a basic set of observations such as respiratory rate, temperature, blood pressure and pain score used to alert staff to any changes in a patient's condition. The data from this system was used to update the electronic patient boards that were available on some of the wards.
- On Ward 39 we found a patient lying low in bed who appeared to be having difficulty breathing and called for staff to help. We noted that this patient had an episode of rapid heartbeat (ventricular tachycardia) earlier that day but this had not been documented fully nor had a medical review been sought. This was brought to the attention of the ward manager to ensure patient safety.
- There was a risk assessment bundle that was completed for each patient on admission. This included risk assessment for bed rails, manual handling, pressure ulcers, a falls care bundle and nutrition (Malnutrition Universal Screening Tool or MUST). During the inspection we reviewed 15 risk assessment bundles and the majority were fully completed. One of the records we saw on Ward 20 had no care plan or risk assessment bundle completed. On ward 39 we saw three records out of seven that had incomplete care plans.
- We reviewed the care record for a patient who had developed pressure sores. The patient's care was clearly documented and care needs had been assessed and responded to appropriately. There was a clear care plan in place and a completed risk assessment. The patient was on the pressure mattress that was recommended following the risk assessment.
- Falls risk assessments were based on patient history of falls and this determined the care and bed location. This was similar to the method used by other hospitals in the area.
- To continually assess patient risk, intentional observation rounds were completed on patients every two to four hours depending on need. Three records out of the seven we reviewed on ward 39 had incomplete intentional round sheets. This meant that patients may have been at risk if they had not been observed regularly.
- Stroke monitors were in place at the bedside of patients who required them. These monitored oxygen levels and blood pressure.
- Staff were not aware of any trust policy for medical admissions to the ward. They told us that they would

liaise closely with the emergency department and expect all the admission paperwork to have been done by the emergency department staff. If there were any issues they would escalate these to the clinical service manager.

- Consultants undertook ward rounds twice a day, once in the morning and again in the afternoon. This meant that patients were seen by a consultant within 12 hours of being admitted onto a ward. During our visit we observed these ward rounds which were effective and well attended by multidisciplinary staff.

Nursing staffing

- Each ward had a planned nurse staffing rota and reported on a daily basis if shifts had not been covered. The National Institute for Health and Care Excellence (NICE) guideline 'Safe staffing for nursing in adult inpatient ward in acute hospitals' was used by the trust but not consistently by all wards.
- Staff reported that the 'red rules' initiative was not yet fully developed. The principals of this initiative included one registered nurse should deliver care to no more than eight patients and the minimum skills mix on a ward should be 60% registered nurses to 40% health care assistants. We saw evidence from the trust that this initiative was being implemented.
- Medical wards displayed nurse staffing information on a board at the ward entrance. This included the staffing levels that should be on duty and the actual staffing levels. This meant that people who used the services were aware of the available staff and whether staffing levels were in line with the planned requirement.
- Ward 39 had recently begun to use the e-rostering system. This was a central system for managing information such as shift patterns, annual leave, sickness and staffing skill mix. Over the previous three weeks there were a number of shifts that had not been covered. On week commencing 22 June 2015, 21 shifts had not been covered; on week commencing 29 June 2015, 13 shifts had not been covered and on week commencing 6 July 2015 two shifts had not been covered. The ward manager informed us that these were additional shifts were it had been requested that one to one care be put in place for a patient with additional support needs.
- In May 2015 the majority of the medical wards' shifts were filled as planned except for the medical assessment unit and ward 21 during the day. The percentage of shifts filled was 79% and 87% respectively for registered nurses.
- A review of staffing over a one month period for two wards showed that the skill mix on ward 39 did not always fall in line with the red rules initiative. On seven occasions from 23 March to 19 April 2015 there were more clinical support workers on duty than registered nurses during the day. On ward 20, between 15 May and 12 July 2015, the skills mix levels were variable and on five occasions there were more clinical support workers on duty than registered nurses during the day.
- On ward 39 there were a number of internationally recruited staff that were still supernumerary and waiting for their registration number from the Nursing and Midwifery Council (NMC). (In the United Kingdom all nurses must be registered with the NMC before they can practice). As their shifts still had to be covered, the ward was using agency staff due to the lack of band 5 registered bank nurses.
- Senior staff said that they tried to use the same bank and agency staff to ensure that they had the required skills to work on the ward. Agency staff were given an induction before commencing work on the wards.
- Ward 39 had 5.2 registered nurse vacancies with 2 new starters commencing in September 2015. Senior staff said that the staffing establishment on ward 39 was unsustainable for the number of beds on the ward (50 beds) as they had been asked to reduce the number of clinical support workers. They were unsure how the new staffing figures for clinical support workers had been decided as they had not been involved in the review.
- On ward 23 there were 2 clinical support worker vacancies which had been appointed to and who were due to commence employment. Staff told us how they were ensuring that there had been continual clinical support worker cover by employing a member of staff on a rolling contract.
- The number of whole time equivalent nurse vacancies across the medical care services was 17.2. The average turnover of nursing staff at the hospital was 8.3%
- Staffing establishments had improved since the last inspection; however failure to provide adequate staff was still on the divisional risk register and still had a

high risk rating, which had not improved since the last inspection. Of note, the risk specifically identified that the nurse staffing ratio on ward 39 and 21 were below the national average.

Medical staffing

- The percentage of consultants working in the trust was 44% which was higher (better) than the England average of 34%. The percentage of registrars was 28% which was below (worse) the England average of 39%. Middle grade and junior doctor levels were about the same as the England average.
- There was, however, a lack of consultants in some services including respiratory and gastroenterology, and this was noted on the risk register. It had been on the risk register since 2011 with a high risk rating. There were actions identified to mitigate the risk, however, the target date for completion of the actions was January 2015 and two actions were still outstanding. These actions were 'internal training for a potential candidate for a senior post' and 'a business case'. There were 15 whole time equivalent medical vacancies. The average turnover of medical staff in the hospital was 21%.
- Junior doctors said that they always had the contact number for consultants and were always supported. However, they said that they were sometimes stretched when there were patients in different locations who required more medical input. Whilst this was a challenge they felt that it was manageable.
- There was an on call rota which ensured that there was a consultant available 24 hours a day seven days a week for advice.
- There had been an increase in the number of cardiology consultants from two to six. These consultants worked across the trust on a six week rotation basis. This had improved patient care and facilitated earlier discharges. It had also reduced the angiogram waiting list from 18 months to three weeks. The consultants were supported by nurse practitioners and specialist nurses.
- Senior management staff said there had been new appointments made in diabetes services and there was succession planning in rheumatology services.
- The hospital used advanced practitioners in gastroenterology services to support the consultants.
- Locum cover was requested through a procurement system. Over the past 6 months the locum cover had been as high as 51.5% of whole time equivalent medical staff. The specialities that had high use of locum cover included elderly care, diabetes, dermatology and rheumatology services at the hospital.

Major incident awareness and training

- Staff were aware of what they would need to do in the event of a major incident. They demonstrated how they would follow the trust policy and how to access key documents and guidance.
- On the mandatory training information that was provided by the trust there was no record of any major incident training for staff.

Are medical care services effective?

Requires improvement

As part of the previous inspection we found there were instances where patients' needs were not effectively met. Outcomes for patients who had suffered a stroke required improvement.

As part of this inspection we found care was provided in line with national best practice guidelines and medical services participated in the majority of clinical audits where they were eligible for. Recent national audits indicated that although there had been progress, the service still needed to make improvements to the care and treatment of people who had suffered a stroke. Most staff said they were supported effectively but the appraisal completion for the division was below the trust target of 90%, ranging from 63.2% for medical staff to 88.9% for nursing staff in bands one to seven. Staff on ward 39 were rotated around specialities to increase the skill mix of staff. However, the ward manager could not tell us how they were assured that ward staff were competent in each area as this was not assessed. We found that staff members' understanding and awareness of assessing people's capacity to make decisions about their care and treatment were variable. Staff did not always follow capacity assessment processes in line with trust policy. People were not always supported appropriately with their nutritional needs.

There was a multidisciplinary approach to care and treatment that involved a range of professionals. There was a joined up approach to assessing and managing patients'

needs. There was evidence of progress towards providing services seven days a week. The relevant information, including diagnostic test results, was accessible to staff in order to provide appropriate care and treatment.

Evidence-based care and treatment

- The service was using national and best practice guidelines to care for and treat patients. Specific National Institute for Health and Care Excellence (NICE) guidelines were included in consultant objectives.
- The service participated in all but two of the clinical audits for which it was eligible through the advancing quality programme. These were diabetes audit and coronary artery bypass graph audit. In February and March 2015 they were not meeting the appropriate care score threshold for stroke, sepsis and for chronic obstructive pulmonary disease (COPD). Action plans were completed following clinical audits to address any areas identified for improvement.
- The hospital had a care pathway in place for managing patients who had a stroke and for patients admitted to ambulatory care. Ambulatory care is medical care provided on an outpatient basis. Staff gave examples of how they were working to improve the stroke care pathway. These included working with the ambulance service to pre-alert the hospital to patients who may require medical care for a stroke and posters around the hospital informing people about how to recognise a stroke. Staff said that the pathway was audited on an adhoc basis only and there were no formal processes in place.
- There were examples of recent local audits that had been completed on the wards. These included cleanliness, documentation and discharge audits. Staff said they received the results of the audits and any learning was shared with them via email.
- Lead consultant objectives included the review and delivery of NICE standards for each speciality in medicine.
- Aseptic technique NICE guidelines(Aseptic technique is a procedure used by medical staff to prevent the spread of infection.) and acute kidney injury NICE guidelines were part of the quality and innovation scheme for the trust for 2015/16.

Pain relief

- Wards had effective systems in place to assess and provide pain relief for patients.
- Patients told us that they received appropriate pain relief when required.

Nutrition and hydration

- Patients told us that the food was very good and they had a choice. Catering staff had access to information of any special dietary requirements for patients.
- People were not always supported appropriately with their nutritional needs.
- For example, we noted a patient on Ward 39 had been left his breakfast and drink in front of him from when we arrived on the ward at 9am until 10.25 am when a support worker was seen encouraging him to have the drink which was then cold. We observed that the cold drink and breakfast were then removed. On checking the patient's food and fluid charts these had not been fully completed for three days. The patient appeared to have a very dry mouth and there was no evidence of mouth care in his care plan. This was raised with the ward manager. On returning to the ward later in the day we found that the food and fluid chart for that day had been filled in retrospectively.
- A patient on ward 39 required feeding via a gastro-enteric tube. This is a device used to provide nutrition to patients who cannot intake food and fluids by mouth. There was a clear plan in place which outlined what the food and fluid intake should be for this patient including specified volumes and times for delivery. On checking the daily fluid monitoring chart the daily intake recorded did not match the amount stated on the plan for three days. This was raised with the matron who acknowledged that further work needed to be done around the completion of fluid monitoring charts but was not clear on how improvements were going to be made. We were not assured that the patient had received the appropriate nutrition in line with the care plan.

Patient outcomes

- The hospital did not provide primary coronary intervention (PCI) as this is provided by another local trust at a specialist cardiac catheter centre. However according to the MINAP audit 2013/14, the number of patients diagnosed with a non-ST segment elevation myocardial infarction (N-STEMI-a type of heart attack that does not benefit from immediate PCI) seen by a cardiologist prior to discharge was better than the

national average at 100%. This was higher than at the last inspection. That said, only 42.1% of patients with an N-STEMI were admitted to a cardiology ward. This was lower than at the last inspection.

- An analysis of the National Diabetes Inpatient Audit 2013(NaDIA) showed the hospital performed better than the England average for 11 out of the 21 indicators and worse than the England average for ten of the indicators. Of particular concern was data showing that only 23% of patients had a foot risk assessment during their hospital stay compared with the England average of 42% and there were 52% of medication errors compared with the England average of 37%. The trust had an action plan in place to improve the outcome for patients with diabetes. The actions included early identification and management of diabetic foot disease and a new insulin chart together with a rolling education programme. The completion date for the action plan was late 2015.
- The trust was highlighted as a 'risk' for the in-hospital mortality indicator - Cerebrovascular conditions in the CQC Intelligent monitoring report May 2015.
- The trust was highlighted as a 'risk' for the Sentinel Stroke National Audit Programme (SSNAP), "Domain 2: overall team-centred rating score for key stroke unit indicator" in the CQC Intelligent monitoring report May 2015.
- The SSNAP is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence-based standards. This highlighted that the service still needed to make improvements to the care and treatment of patients who had suffered a stroke. The January to March 2015 audit rated the hospital overall as a grade 'D', this was an improvement from the last inspection when the hospital was rated as the lowest grade, grade 'E'. There was an action plan in place in response to the SSNAP audit to improve stroke service provision.
- The trust did participate in the joint advisory group on gastrointestinal endoscopy (JAG). The JAG ensures the quality and safety of patient care by defining and maintaining the standards by which endoscopy is practised.
- The average length of stay for elective medicine at the hospital was 8.4 days. This was longer (worse) than the England average of 4.5 days. For non-elective medicine the average length of stay 5.5 days. This was shorter (better) than the England average of 6.8 days.
- The elective and non-elective readmission rates were either the same as or better than the England average for all specialities except elective clinical haematology and non-elective cardiology.

Competent staff

- The trust had no clinical supervision policy for nursing staff. Qualified staff told us that there were no formal systems in place for clinical supervision. A senior clinician said that they had tried to implement clinical supervision but found resistance from band 5 nurses and senior management staff. However, staff did have access to meetings with their line manager on request. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice.
- Most staff told us they had received an appraisal in the last 12 months although on Ward 39 senior staff said seven out of eight band 6 nurses' appraisals were outstanding. Appraisals included objectives which were based on trust and divisional objectives as well as personal objectives.
- The appraisal completion rate for the division was below the trust target of 90%. The lowest completion rate was medical staff at 63.2% and the highest completion rate was for staff in bands one to seven at 88.9%. This meant not all staff were receiving an adequate opportunity to discuss their performance and development.
- Some staff felt there was a lack of opportunity for personal development.For example, one nurse had ambitions to become a nurse consultant but felt this had not being reflected n their appraisal.
- The trust had recently recruited a number of international nurses. These were assigned a mentor on the ward and worked alongside practice educators. They undertook nurse duties under supervision until they were registered with the Nursing and Midwifery Council (NMC).

- Staff on ward 39 were rotated around specialities to increase the skill mix of staff. However, the ward manager could not tell us how they were assured that ward staff were competent in each area as this was not assessed.
- There was a practice facilitator available for medical services who supported nursing staff to become competent in procedures such as venepuncture (taking blood), cannulation and supporting patients who required nasogastric tubes. They worked across all wards.
- There was a preceptorship programme which supported junior nursing staff. Competency in care procedures were assessed by more senior staff. Once they had completed the programme successfully they were then able to lead a shift on a ward.
- The trust was involved in the apprenticeship nursing scheme with the skills for health academy and were undertaking a national vocational qualification (NVQ) in care. This helped ensure that any future applications for nursing posts were from competent people who had the skills and experience required.
- The trust had been working with Lancaster University, to support the development of clinical leaders. The division was supporting two members of staff on the clinical leadership development level 7 programme.

Multidisciplinary working

- There was a multidisciplinary approach to care and treatment that involved a range of professionals. There was a joined up approach to assessing and managing patients' needs.
- We observed handovers, which included ward staff on duty such as clinical support workers and therapy staff. There was effective communication and they were well structured.
- Daily ward meetings were held on most of the wards we visited. These were called board rounds and they reviewed discharge planning and confirmed actions for those people who had complex factors affecting their discharge. We observed two board rounds and saw that they were well attended by a range of professionals.

Seven-day services

- There were two nurses who specialised in stroke services in the hospital who covered seven days a week 8 a.m.to 4 p.m.
- A plan had been developed so that acutely ill medical patients in the hospital had the same access to medical care during the weekends as on a week day. The plan outlined key objectives such as a consultant presence on wards over seven days with ward care prioritised in doctors' job plans. The plan outlined an analysis of gaps and actions required but there was no date for full implementation.
- The hospital had a doctors' on-call rota for evenings and weekends.
- Staff told us that diagnostic services were available 24 hours a day, seven days a week.

Access to information

- Medical and nursing staff reported information systems to be good with timely access to results of investigations and tests.
- Discharge information was sent through to GPs following discharge. In complex cases staff would telephone the GP directly with the information.
- There were computers available on the wards we visited which gave staff access to patient and trust information.
- Completed audits from Ward 39 showed that some information, such as next of kin details was not available for the receiving ward when patients were transferred via the urgent and emergency care pathways. This was being escalated to senior management by the matrons to consider what actions needed to be taken.
- Policies and protocols were kept on the hospital's intranet which meant all staff had access to them when required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There were systems in place to obtain consent from patients before carrying out a procedure or providing treatment.
- Staff understanding and awareness of the need to assess people's capacity to make decisions about their care and treatment was variable. Some knew the principles of the Mental Capacity Act whilst others did not. This included nursing and medical staff.
- Some staff on ward 39 said that they had never seen a capacity assessment form and could not tell us where to find it.

Medical care (including older people's care)

- A doctor on ward 39 described the capacity assessment form but thought that deprivation of liberty safeguards were only needed for ambulatory patients (patients seen for medical care on an out-patient basis) who were trying to leave the ward.
- Some assessments clearly recorded specific decisions and the reasons for the judgment made, while others did not. Of the 11 records we reviewed for people who had been judged as lacking capacity, only three had a capacity assessment or best interest decision recorded. This was on ward 39, ward 20 and the acute medical unit.
- Some staff had not received deprivation of liberty safeguards (DoLS) or Mental Capacity Act 2005 (MCA) training. This training was included in the safeguarding training for clinical professionals. 85% had completed this training.
- Senior management staff recognised that there was a lack of recent in-depth training on MCA and DoLS.
- Within the risk assessment bundle documentation, there was clear guidance for staff on the Mental Capacity Act 2005 and deprivation of liberty safeguards.
- On Ward 20 and Ward 39 it was observed that bed rails were in place for a patient who had dementia. There was no record in their notes or care plan that a MCA assessment had been done, or a best interest decision had been made. This was not in line with in the trust's standard operating procedure for using bedrails safely and effectively.
- Within the trust there had been an increase in the number of DoLS applications. These were monitored by the trust safeguarding lead to ensure that they were appropriately authorised.

Are medical care services caring?

Good

As part of the previous inspection we found response rates to the Friends and Family test were below the national average. At this inspection we found response rates had improved and the majority of patients would recommend the service to their family and friends.

Patients told us staff were caring, kind and respected their wishes. We saw staff interactions with people were person-centred. Patients received compassionate care and their privacy and dignity were maintained in most circumstances However, on one of the wards we visited extra attention was needed to ensure the dignity of patients was maintained when using communal areas. Patients were involved in their care, and were provided with appropriate emotional support in the majority of cases. However, whilst some staff said that they had sufficient time to spend with patients when they needed support, other staff felt that time pressures and workloads meant that this did not always happen.

Compassionate care

- The Friends and Family test is a national initiative to gain feedback from patients following their admission to hospital. The average response rate for wards 37 and 39 had increased since the last inspection from 5.7% and 2.8% to 68.9% and 37.2% respectively at the time of the inspection. The percentage of patients who would recommend the medical wards to friends and family ranged from 80% for ward 6 to 100% for ward 22.
- Patients and those close to them were treated with respect, including when receiving personal care.
- Patients felt supported, well cared for and involved in their care.
- We carried out a Short Observational Framework for Inspection (SOFI) on ward 39. SOFI is an observational tool used to help us collect evidence about the experience of people who use services, especially where they may not be able to fully describe these themselves because of cognitive or other problems. This showed that interactions between staff and other people were positive, respectful and caring.
- Most patients we observed were well presented and appeared comfortable in their surroundings.
- Patients' dignity was respected while they were being supported with personal care tasks and privacy curtains were used when staff were assisting patients.
- On Ward 20 we saw female and male patients sitting in the communal area in their nightclothes and hospital gowns. As a result, their dignity was not always maintained appropriately.

Understanding and involvement of patients and those close to them

Medical care (including older people's care)

- Patients were allocated a named nurse and consultant. Patients were aware of these and they were displayed on a board above the bed.
- Patients said they had been involved in their care and were aware of the discharge plans in place. Most patients could explain their care plan.
- Patients said they felt safe on the ward and had received orientation to the ward area on admission.
- Family members said that they were kept well informed about how their relative was progressing.
- We observed staff consulting with a patient when they were undertaking a procedure, describing how they were going to do it and why. They listened to the patient when they asked for things to be done if a different way.

Emotional support

- Some staff said that they had sufficient time to spend with patients when they needed support, but other staff felt that time pressures and workloads meant that this did not always happen.
- Staff said that an extra staff member could be requested if a person needed specific one-to-one support but that this did now always happen due to lack of available staff.
- Visiting times met the needs of the relatives we spoke with. Open visiting times were available if patients needed support from their relatives.
- The hospital had specialist nurses that could offer additional support and advice for example, for patients recovering from a stroke.
- Chaplaincy services were available for patients and their relatives if required.

Are medical care services responsive?

Requires improvement

As part of the last inspection we found medical services were experiencing capacity challenges and difficulties in managing the number of medical outliers. Patients experienced delayed discharges and this had an adverse impact on the average length of stay in hospital.

At this inspection we found the bed occupancy rate for the hospital had been consistently above 90% over the six months prior to inspection. Ward 39 had implemented zoned areas to help with access to beds; however, there were no formal systems in place to evaluate whether this had improved the outcome for patients. There were a number of patients who experienced multiple ward moves during their stay. There were also a high number of patients placed on wards that were not best suited to meet their needs (medical outliers). There were lead consultants who were responsible for reviewing outlying patients. Matrons would verbally report if outlying patients had been seen by a member of the medical team but this was not formally documented on the daily patient flow report. There were difficulties for patients based in medical unit two when accessing treatment in the main building as they had to be transported by ambulance.

The trust was working in partnership with other organisations to help meet the needs of people. There was a focus on effective discharge planning for patients and the implementation of electronic whiteboards had improved the information available to staff to improve patient care. There were good facilities for patients who had had a stroke on one ward and there was evidence that there was learning from complaints. There were systems in place to support people living with dementia however; staff told us that there had been difficulties in accessing mental health services

Service planning and delivery to meet the needs of local people

- Senior staff said that the trust was developing a winter pressures plan to cope with increased demand for beds in the coming months. The trust was engaging with partner organisations, such as the local authority and clinical commissioning groups, to address this area of concern.
- Senior management staff explained that each year they looked at capacity and demand from the previous year to plan the services required for the following year.
- Patients in medical unit two had to be transported by ambulance to the main hospital for investigations. This was due to the unit being separate from the main building which did not have a direct route that was safe for patients. This had been put on the medical services risk register in 2014 with a moderate risk rating score. There were actions identified to mitigate this risk which was due to be updated in May 2015. There was also an additional risk added in 2014 for out of hours accessibility to the main building. The trust told us that actions had been identified.

- There was only one oxygen and suction point available on each six bedded bay on ward 20. A patient who required continuous oxygen was being given oxygen via a portable cylinder rather than being moved to the bed which had the oxygen and suction point. The patient in the bed where there was an oxygen point did not require continuous oxygen.
- In the medical unit two, toilets on the wards could be used by both female and male patients. Staff told us that a notice on the toilet doors was used to denote if the toilet was to be used by male or female patients. We observed that a notice on one toilet was turned to state male but was outside a female bay.
- On ward 21, patients in beds 5 and 6 had to walk through the central communal area to use the toilet and shower facilities.

Access and flow

- The bed occupancy rate for the hospital had been consistently above 90% over the six months prior to inspection. It is generally accepted that, when occupancy rates rise above 85%, it can start to affect the quality of care provided to patients and the orderly running of the hospital.
- Information provided by the trust showed there was a shortage of medical beds and a high number of patients placed on wards that were not best suited to meet their needs (also known as medical outliers). Between January 2015 and June 2015 data showed there had been 951 medical outliers at the hospital. The medical services risk register showed that outliers had been on the risk register since 2011 with a low risk rating score. The trust told us that actions had been identified.
- There was a standard operating procedure for outlying patients which was ratified on 28 June 2015. This was to be shared with staff by the matrons in July 2015. The development of the procedure was part of the emergency recovery plan 2014. As part of this plan a new structure was placed around the patient flow meetings which included a ward status report completed by the matrons. The trust told us that matrons who had medical outliers on their ward would verbally report if they had been seen by a member of the medical team. This was not formally documented on the daily patient flow report. The only documented evidence that a medical outlier had been reviewed would be in the patient notes. There were lead consultants who were responsible for reviewing outlying patients. There was no documented organisational overview that patient needs were being met apart from the total number of medical outliers.
- The hospital held patient flow meetings regularly throughout the day during the week to review and plan bed capacity and respond to acute bed availability pressures. We attended a patient flow meeting during our visit. Although medical outliers were discussed this was not in detail considering the high number of outliers in the hospital.
- Senior nurses said that there was good strategic management of bed capacity across the hospital site and effective liaison with clinical commissioning groups.
- 921 patients had moved wards more than once during their stay; this was 6% of the total number of patients admitted to the hospital between April 2014 and April 2015.
- The referral to treatment times for cardiology, dermatology and gastroenterology were meeting the standard of 90% (percentage referral to treatment within 18 weeks).
- There was a clear focus on effective discharge planning for patients and wards had a designated discharge co-ordinator who was responsible for discharge planning.
- Electronic boards were in place on some of the wards which monitored the flow of patients. This included their medication, completed early warning scores, test results and any patient moves to other wards.
- Zoned areas had been introduced on Ward 39 which was a large 50 bedded ward. The ward had been split into different speciality zoned areas with one of the aims being an improvement in the flow of patients. Medical staff reported that it had improved communication but could not comment on whether it had improved the flow of patients. The project plan for the zoned areas did not include an evaluation of the outcome for patients.
- Improvements had been made over the last 12 months with the delivery of a five day ward round. The trust was looking at delivery of this best practice to seven days a week. A ward round standard operating procedure had been developed which was being tested out across all specialities. This was to optimise the patient journey.

Meeting people's individual needs

- Wards used a butterfly symbol on patient information boards to indicate that a patient was living with dementia.
- On some of the wards there was enhanced décor around doors and in toilets to help people with dementia. This included the use of red toilet seats to make them more visible.
- Patient leaflets were available on wards but not always in an accessible format. Accessible information leaflets for people with a learning disability were seen on Ward 23.
- On ward 23 there was a dedicated therapy treatment room for use by the stroke service. This contained adjustable height plinths and therapeutic equipment so that patients could benefit from physiotherapy activities such as balance and gait training. Staff ensured that this room was kept gender specific if patients were in their nightclothes. This meant that patients' dignity was maintained at all times. There was also a well-equipped physiotherapy gym for patients to use on ward 23.
- There were translation services available via language line. This is a telephone interpreting service. Staff told us they had used this service in the past and it was effective.
- Generally we saw that people had access to call bells and staff responded promptly. However, on Ward 39, there were a number of patients who did not have call bells within reach to summon help if needed.
- Staff told us that there had been difficulties in accessing mental health services and that calls made to the service were not returned in a timely way. They were not always responded to in the same day.

Learning from complaints and concerns

- People knew how to raise concerns or make a complaint. The trust encouraged people who used services to provide feedback about their care. Complaint procedure leaflets were available on wards.
- Senior staff said they were now working to achieve 'on the spot' resolutions to concerns where possible.
- Examples were given of the last complaint received on the wards and the findings from the review of the concern raised. There was evidence that themes had been identified from the complaints received. These included inadequate care and treatment, communication and attitude of nursing staff. From the information we saw it was not clear if any actions had been taken to improve these areas and address the issues.
- Patients had raised issues on one ward regarding the condition of a shower room and as a result the room had been refurbished.
- Learning from complaints was disseminated via team meetings.
- Some wards also displayed the compliments they received.

Are medical care services well-led?

Requires improvement

As part of our inspection in 2014 we found that wards and departments were not always well-led at a senior level and there was a disconnect between the staff providing care and the executive team. Staff morale was generally low and staff engagement with the development of the trust's vision and strategy was mixed. Governance meetings were not happening regularly.

At this inspection we found the visibility of senior management had improved and there were information boards to highlight each ward's performance. Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history.

Divisional goverance board meetings were held on a monthly basis. Minutes from the meetings showed that a monthly report, which included risk registers, mortality incidents, audits and safety alerts, was discussed at the meeting. However, it was not always clear how the learning was then cascaded to ward staff or whether it had already been shared.

The majority of staff told us leadership at ward level had improved, with clearer communication. However there was a lack of leadership on ward 39 with no clear governance systems in place to evaluate and monitor changes in systems and processes. Most staff felt valued and were able to tell us about the trust's vision and strategy. All staff were committed to delivering good, compassionate care and were motivated to work at the hospital.

Medical care (including older people's care)

Vision and strategy for this service

- Senior staff spoke positively about the board's vision and strategy, 'Better care together'. Services were working in partnership with clinical commissioning groups and local health and care providers to review how patient services were delivered. Staff were able to tell us about the trust's values.
- Medical staff had clear objectives which reflected the trust's strategy such as ensuring services were delivered within financial plans and improving the quality of patient care.

Governance, risk management and quality measurement

- It was clear the service had taken steps to address some of the issues identified during our previous inspection, for example processes to improve discharge. However as part of the last inspection we identified concerns in relation to staffing and skill mix, completion of patient records and ward 39. As part of this inspection we found completion of care records was still variable and there were ongoing challenges with both nursing and medical staffing and skill mix. Safety data indicated that there were a high number of falls. Ward 39 remained an ongoing concern in relation to staffing, quality of patient care and leadership. As a result we were not assured that there were robust systems in place within the service to monitor and improve the quality of services provided.
- Staff at all levels knew that there was a divisional risk register and ward managers were able to tell us what the key risks were for their area of responsibility.
- Staff demonstrated how they were able to access the risk register on the trust systems. However, it was noted that there were a number of risks on the ward level risk register for Ward 39 that required updating.
- The divisional risk register had a number of risks that had been on since 2011. Some of the risks were past the target date for completion of actions identified to mitigate the risks. Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history
- Matrons met monthly with ward managers to discuss the monthly performance reports and undertook a weekly ward round. This involved talking with patients and staff. Looking at documentation and charts and checking equipment. These were formally recorded. Band 6 nursing staff from other units undertook the ward round on occasions to share learning.
- Every six months, matrons undertook the care quality assessment tool which incorporated the CQC standards. This identified areas of good practice and areas for improvement.
- Divisional governance board meetings were held on a monthly basis. During the meetings, a review of the divisional risk register, incidents, safety alerts, infections audits and mortality incidents were undertaken.
- Minutes of the medical divisional governance meeting showed that a monthly report, which included learning from incidents, was discussed at the meeting. However, it was not always clear how the learning was then cascaded to ward staff or whether it had already been shared.
- Senior staff were able to tell us how their ward's performance was monitored, and how performance boards were used to display current information about the staffing levels and risk factors for the ward.

Leadership of service

- The majority of staff told us leadership at ward level had improved, with clearer communication. However there was a lack of leadership on ward 39 with no clear governance systems in place to evaluate and monitor changes in systems and processes.
- Staff reported that senior staff were visible and approachable.
- Staff could explain the leadership structure within the trust and the executive team were more visible and accessible to staff. Staff said that the static leadership had helped them know who to go to for help with any concerns.
- Matrons provided seven day cover on a rota basis as a point for advice on site for all specialities.
- A senior member of staff said that formal leadership and management courses were not available but they had received support from other members of staff when they required help in managing a ward.

Culture within the service

- Staff said they felt supported and able to speak up if they had concerns. They said there had been an improvement in staff morale.

- There had been an improvement in the number of senior staff walk rounds which gave staff the opportunity to raise concerns.
- Senior medical staff were now working more across the three main hospital sites to encourage a more joined up approach across the trust. The policies in place were becoming more trust-wide than location based policies.
- The trust pulse staff survey showed that in the medical division 84% staff were motivated to come to work.
- The 2014 staff survey showed that 45% of staff in medical services would recommend it as a place to work. The survey also showed 59% of staff working in medical services would be happy for a friend or relative to have treatment at the trust.

Public engagement

- Board meeting minutes and papers were available to the public online which helped them understand more about the hospital and how it was performing.
- There was a limited approach to obtaining the views of people who use services and we saw no systems in place on the wards we visited. However, the trust monthly board meetings included a patient story to highlight patients' experiences of using the hospital's services.
- The hospital participated in the NHS friends and family test giving people who used services the opportunity to provide feedback about care and treatment. In May 2015 the friends and family test showed that 93% of patients would recommend the hospital to friends or a relative.

Staff engagement

- Staff said they had been to an 'input' day around service planning but had not been able to be more involved as their main priority had been patient safety and due to staffing numbers had not been able to attend any other events.
- The trust celebrated the achievements of staff by having a 'star of the month' which colleagues nominated. The medical services had had a number of staff recognised for their work at the trust.
- Staff participated in the staff survey. This included how staff felt about the organisation and their personal development. In the 2015 staff survey 77% of staff working in medical services felt the training and development they had undertaken had helped them to deliver a better patient experience and 77% felt it had helped them to the job more effectively. 51% felt that they were valued by the organisation against the national average of 62%.

Innovation, improvement and sustainability

- Innovation and improvement was encouraged, for example utilising a day room as a therapy room for patients and refurbishing an unused area on a ward as a confidential computer zone for medical staff. However, staff told us they were not always able to recommend changes to processes due to time pressures. Some staff felt well supported in being able to voice their opinions on how services should be run, while others did not.
- The trust had developed an in-house e-Whiteboard system for the medical wards. This interacted with the trust's other computerised patient systems and simplified access to information for nurses, facilitating active management of patient journeys, discharge processes and bed state.

Surgery

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Royal Lancaster Infirmary provides a range of surgical services including: urology, ophthalmology, trauma and orthopaedics and general surgery (such as colorectal surgery). There are four surgical wards, a day case ward, an acute surgical unit and four general theatres that carry out emergency and elective surgery procedures and two day case theatres.

Hospital episode statistics data for 2014 showed that 15,600 patients were admitted for surgery at the hospital. The data showed that 44% of patients had day case procedures, 13% had elective surgery and 43% were emergency surgical patients.

As part of the inspection, we visited the main theatres, the pre-operative assessment unit, the surgical admission unit, the day case unit, the acute surgical unit, ward 36 (the trauma and orthopaedic unit), ward 33 (the ear nose and throat, maxilla-facial and general surgical ward), ward 34 (colorectal and urology) and ward 35 (elective orthopaedics).

We spoke with eight patients. We observed care and treatment and looked at seven care records. We also spoke with a range of staff at different grades including nurses, doctors, consultants, ward managers, general managers, theatre managers, the assistant chief nurse, and the matron for quality assurance, the matron for theatres, the adult safeguarding lead nurse and the divisional clinical lead. We received comments from people who contacted us to tell us about their experiences and we reviewed performance information about the trust.

Summary of findings

Following our last inspection we rated surgical services at the Royal Lancaster Infirmary as "Good" overall.

At this inspection we have rated the services as "Requires Improvement". This is because there was no system for identifying themes from incidents and sharing actions to prevent recurrence. The written policies and procedures for medicine administration, which were being used by staff at the time of the inspection, were out of date. However, the electronic versions were in date. There was a high nursing and theatre staff vacancy rate resulting in a high use of agency staff. Not all practices and procedures in operating theatres or the ward areas were based on the relevant guidance. Evidence was gathered for audit of care and treatment but the outcomes and resulting actions were not known to all relevant staff which limited the opportunity to learn.

Readmission rates (after surgery) were worse than the England average. Patients with a hip fracture were not seen by an ortho-geriatrician within timescales which were in line with national guidance. Appraisal rates for staff were lower than the trusts' target. There was a lack of clarity of the role for overseas nursing staff whilst awaiting their registration to practice in the UK. Staff were not clear how the mental capacity of a patient impacted on their role. Referral to treatment times for

Surgery

patients admitted to the hospital were worse than the England average; however trust wide initiatives had been launched to reduce these and improvements had been made.

However, the environment and equipment were visibly clean and tidy with good infection control measures in place. Measures were in place to assess and respond to patient risk. There was a low medical staff vacancy rate and there was effective internal and external multi-disciplinary working. Patients spoke very highly of the attitude of staff and told us that staff treated patients with respect and attended to patients quickly when they requested assistance.

Are surgery services safe?

Requires improvement

Staff were unclear what should be reported as an incident which could result in lack of investigation and actions. There was no system for identifying themes from incidents and sharing actions to prevent recurrence. One specific invasive surgical procedure was carried out in an environment which did not meet clinical guidelines for infection prevention and control during surgery. The written policies and procedures for medicine administration, which were being used by staff at the time of the inspection, were out of date. However, the electronic versions were in date.Not all patients' records were kept confidential and there was no robust system for tracking of paper notes which resulted in poor management of the storage and tracking of records. Staff understood their responsibilities to protect adults in their care but were not confident to report any concerns to outside agencies. Mandatory training completion levels were variable.

There was a high nursing and theatre staff vacancy rate resulting in a high use of agency staff. There were nurses working on the surgical wards who had been recruited from overseas and were awaiting their registration documents to allow them to practice in the UK. In the interim, there was a lack of clarity about their role and responsibilities and there was nothing to denote any restrictions on their practice. This was brought to the attention of the deputy chief nurse during the inspection.

The environment and equipment were visibly clean and tidy with good infection control measures in place. Measures were in place to assess and respond to patient risk. There was a low medical staff vacancy rate.

Incidents

- Between May 2014 and June 2015 there had been one never event. Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. This incident had involved wrong site surgery. The recent never event was still being investigated but initial findings highlighted a lack of participation by all theatre personnel in one element of the '5 steps to safer surgery' procedure.

Action had been taken through discussions with individual personnel as necessary; however theatre staff said they were unaware of any ongoing monitoring or specific actions being taken as a result of failures with compliance.

- There were 25 serious incidents reported across the trust in the surgical services division between May 2014 and April 2015 which included six cases of delayed diagnosis and four grade 3 pressure ulcers. All serious incidents were subject to an investigation using a root cause analysis approach.
- Between 16 April 2015 and 16 May 2015 there had been 725 incidents reported in surgical services at this hospital with 30 of them identified as a near miss. Medicines management had the highest number of total incidents reported (94 in total). There were no specific plans in place to investigate this theme of incidents further or address any common issues.
- Staff were unclear what should be reported as an incident which could result in lack of investigation and actions to prevent recurrence. One example was cancellations of operations. One senior staff member told us the incident rate was so low they did not feel they had a “high level of expertise” in knowing what to report.
- Some staff groups discussed learning from incidents during their meetings. This included the pre-operative assessment staff who met monthly at the hospital and every three months as a trust wide team. These staff received feedback from incidents they had reported and learning from investigations were shared with staff at ward meetings, through e-mail and the monthly newsletter.
- Weekly mortality review meetings took place. These were attended by a core group of clinicians; however in order for mortality cases to be fully reviewed more doctors were required to join the process if the meetings were to continue. In May 2015 70% of deaths were reviewed. A process had been put in place to send summaries of all surgical and orthopaedic deaths to the respective clinical leads and audit leads. These deaths were discussed on alternate months at the audit meetings and where necessary actions put into place to improve practice. There was anaesthetic presence at these meetings.
- Senior staff were aware of their responsibilities under the Duty of Candour regulations. The Duty of Candour is a regulatory requirement. The aim of the regulation is to ensure services are open and transparent with people who use services and inform and apologise to them when things go wrong with their care and treatment.

Safety thermometer

- The NHS Safety Thermometer allows teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (in patients with a catheter) and venous thromboembolism.
- Safety Thermometer information between March 2014 and March 2015 showed there was a low number of falls with 10 reported in the period. However, there had been 54 pressure ulcers. The prevalence rate had remained consistent throughout the period. However, from December 2014 there had been an increase. There had been 36 catheter acquired urinary tract infections reported. There had been an increase in the prevalence rate from June 2014 to August 2014, with rates returning to a similar level from August 2014 onwards.
- Information about harm free care was displayed on boards at the entry to all wards and departments.
- Staff told us this information was used to inform them, during ward meetings and shift handovers, of any identified shortfalls in harm free care and changes to practices as a result.

Cleanliness, infection control and hygiene

- The wards, theatres and clinical areas were visibly clean and tidy.
- We observed staff wearing personal protective equipment which was available as required. Hand gel was available at the entrance to each ward area.
- Pre-operative screening for MRSA was carried out and there had been no MRSA infections across surgical services at the hospital to the end of February 2015. Staff in the surgical admissions department said in 99% of cases they received the test results prior to the patient being admitted.
- Between April 2014 and February 2015 there had been three avoidable cases in the surgical and critical care division at Royal Lancaster Infirmary. There had been no learning which had resulted in additional measures to prevent infection as a result.
- A Public Health England report from the three month period July to September 2014 showed a 3.3% surgical site infection rate following knee replacement surgery at the hospital. Data showed that over a period of four

years, the hospital had performed slightly better compared to the national average. From July to September 2014 there was a 4.3% surgical site infection rate following hip replacement surgery. Data showed that over a period of four years, the hospital had performed slightly worse than the national average.

- In the surgical admissions department, the curtains between the cubicles were made of fabric and had no replacement dates or dates of cleaning on them. Staff did not know when the curtains should be changed. This meant that curtains may not be routinely cleaned or replaced, which could present an infection control risk.
- Caudal epidural injections (injection into the base of the spine) were performed in the ward area of the day surgery unit. This practice increased did not meet best practice requirements in line with the Royal College of Anaesthetists guidance: "Recommendations for good practice in the use of epidural injection for the management of pain of spinal origin in adults" 2011.

Environment and equipment

- There was a limited amount of equipment for patients with a physical disability in the surgical admissions unit. There was no moving and handling equipment and limited space throughout the unit for patients to mobilise safely, especially if they used mobility equipment.
- Emergency resuscitation equipment was in place and records indicated that it had been checked daily, with a more detailed check carried out weekly as per the hospital policy.
- In the operating theatres, records indicated that all equipment had been checked in line with the relevant guidance.
- Staff told us they had the equipment they needed to do their jobs and any repairs were completed in a timely way.
- Records showed that equipment was serviced and maintained within the necessary timescales.

Medicines

- Medicines, including medical gases were securely stored and records indicated that the relevant stock checks were completed and recorded.
- Fridges were locked and records indicated that temperatures were checked and recorded.
- The written policies and procedures for medicine administration, which were being used by staff at the time of the inspection, were out of date. However, the electronic versions were in date.
- The guidelines for ward administration of intravenous morphine which was dated August 2007. It was not clear whether this was the date the guidelines were produced or when they were last reviewed.
- Patients admitted through the surgical admissions department should have had regular medicines prescribed by the doctor so that they could be administered throughout their hospital stay. Ward staff said this was often not done and led to delays in patients receiving their medicines. This had not been escalated and there had been no audit to understand the scale of the issue.
- Medicine administration charts contained all the required information including known allergies.
- Medicines had been identified as a high risk area by the trust and additional support, training and competence assessment had been introduced for nurses recruited from overseas to ensure they were able to safely administer medication prior to them working alone.

Records

- Staff in the surgical admissions department told us there were times when a patient's records were not available. Data for elective patients was collated monthly by medical records staff and shared with the executive teams Non availability of case notes initiated a clinical incident report and is investigated fully. Between June and September 2015 availability ranged from 98% to 99%. Since April 1st 2015 there had been a total of 7 incidents relating to 'no case note' availability and this had resulted in 1 cancelled operation.
- n occasions when patients attended the admissions unit without their records being available nurses in the unit said they would begin the process of gathering the patient's information again.
- The arrangement of the IT screens in the surgical admissions unit meant patients in the waiting areas could clearly see the computer screens. The computers were used to access confidential patient information. This meant that confidential patient information was not always protected.
- There was no robust system for tracking of paper notes in place which resulted in poor management of the

storage and tracking of records. We saw that in some areas, for example the surgical admissions department, there was a very large quantity of notes stored within a walk in cupboard. These were for patients who were due to be admitted or had their operation cancelled. There was one part time administrator in this area therefore the nurses had to try to manage the storage of records within their clinical duties.

- The pre-operative assessments we reviewed had been fully completed and contained the necessary information such as past medical history, medicines and risk assessments.
- Nursing and medical records on the wards were kept securely in locked cabinets.
- We looked at nine patient medical records, which varied in the legibility and quality of information documented. Some contained all the relevant information whilst others had illegible writing and sections that were incomplete such as the medicine record and the sepsis screening tool. This meant for some patients the relevant information necessary for their care was not available.
- Senior managers were aware that records for blood transfusions were not being adequately completed. Incident reports had been submitted about not signing for units of blood taken from the fridge and transfusion paperwork being incomplete. One ward manager had addressed concerns with individual staff and further training had been provided to improve the quality of records. None of the incidents reported had resulted in harm to patients.
- Computerised information boards had been introduced onto the wards. These provided information about each patient such as completion of admission records, whether required tests had been done and any specific needs or risks for that patient such as dementia in the form of symbols. On two wards, we found not all staff were familiar with the symbols which meant they did not know which assessments or observations were up to date. When the boards were flashing red we were told this indicated that specific task had not been completed. On one ward with 23 patients, the symbols for 12 of them were flashing and several were flashing on the other ward. Staff said the tasks had been completed, but this computerised record had not been updated.

Safeguarding

- Staff had received training in the recognition of abuse, the types of abuse that may occur and their responsibilities to report it. In the critical care and surgery division 87% of staff had completed level 1 safeguarding of adults and children.
- In addition, the trust's lead for adult safeguarding had provided more in depth training for 1,800 staff members across the trust since December 2014. This included all grades of nursing and medical staff and they received information about abuse, domestic violence, and prevention of terrorism. External speakers attended this course and staff said it enhanced their understanding of these potential safeguarding issues.
- Despite this training staff were unclear of the process to follow outside of normal working hours to report any concerns they had with regard to the protection of an adult. Those we spoke with, including ward managers, would report their concerns via an incident form, to the safeguarding lead nurse for the trust. This nurse was available Monday to Friday 9am to 5pm with no-one on call outside of these hours. This meant there could be a delay in alerting the necessary authorities when there were concerns about a patient's safety. The lead person was aware that more needed to be done to ensure referrals were made by staff members themselves.

Mandatory training

- Mandatory training was delivered as a mix of e-learning and face to face training which staff said was adequate to meet their needs.
- There was a system for alerting ward managers when staff on the wards were due to update their mandatory training.
- Information provided by the trust showed whilst most of the training modules were around 90% complete, some training was outstanding for a high number of staff. This included fire safety which 68% of staff had completed and conflict resolution at 70%.

Assessing and responding to patient risk

- Staff used the World Health Organization's surgical safety checklist and the '5 steps to safer surgery' approach in theatres.
- The trust's policy stated monthly audits of compliance using the 5 steps to safer surgery should be completed in every theatre. We were told compliance with this varied between the theatres with some not completing this audit. At the time of our visit no action had been

taken to address this issue despite managers stating that a lack of compliance with the safer surgery checklist had been identified following a recent never event.

- There was no policy or procedures in place for the marking of surgical sites for maxilla facial surgery. This did not meet with the World Health Organisation's Safe Surgery guidelines which state: "The Universal Protocol states that the site or sites to be operated on must be marked. This is particularly important in cases of laterality". This meant practice was not in line with current guidance.
- Theatre recovery and nursing records included an early warning score chart to alert staff if a patient's condition was deteriorating. These had been fully completed in the records we looked at.
- Staff were aware of the procedure to follow should a patients' condition quickly deteriorate. This included calling for emergency assistance out of hours.
- There was a pre-operative admissions anaesthetic clinic for patients with multiple medical concerns. This meant high risk patients had an assessment for any risks associated with anaesthesia completed prior to them being admitted for surgery.
- A sepsis assessment and care pathway had been developed approximately two months prior to our inspection. Prior to that it had been included as part of the early warning score tool. Staff told us the new system meant patients at high risk of infection were identified and managed more quickly than previously.
- There were medical outlier patients on one surgical ward (patients who should have been placed on a medical ward). Staff told us there was no routine ward round for the medical patients. Nurses would contact the doctors on the medical team should they require support and the response was variable. Sometimes there was a delay which meant medical patients on surgical wards may not be seen in a timely way.

Nursing staffing

- The expected and actual staffing levels were displayed on notice boards in each area we inspected and these were updated on a daily basis.
- The wards and theatres we inspected had sufficient numbers of trained nursing and support staff with an appropriate skills mix to ensure that patients received the right level of care.
- A month prior to the inspection, an electronic tool for completing the theatre staff rota had been put into place. Managers told us this meant the rota was now completed up to six weeks in advance which was an advantage for their staff. However, the operating lists were completed two to three weeks ahead and therefore the staff rota may be insufficient for the operations listed. This resulted in late changes to the rota. There were plans for the operating lists to be completed five weeks in advance.
- The band 7 staff in theatre had no management time in their contracted hours. This meant they were not supernumerary and had to complete their management duties around the clinical needs of the theatres.
- We were told by managers the staff turnover in theatres was high and "could be 20%". Data provided by the trust showed that in May 2015, medical staff turnover rate was 11.4% and the nursing staff turnover rate was 6.5%.
- The vacancy rate for nurses in the surgical division in May 2015 was 12% which was the highest it had been since June 2014 and an increase of 9% from April 2015. Recruitment had been carried out including that of nurses from overseas.
- There were seven full time operating department personnel vacancies at the time of the inspection and agency staff were being used when necessary.
- In June 2015, 16.5% of full time posts were filled by agency staff across the surgical services. Where possible this was consistent agency cover to provide continuity with staff that were familiar with the working practices of the environment.
- There were nurses working on the surgical wards who had been recruited from overseas and were awaiting their registration documents to allow them to practice in the UK. In the United Kingdom, all nurses must be registered with the Nursing and Midwifery Council (NMC) in order to practice. Upon registration with the NMC, nurses are given a pin number to identify them on the register.
- In the interim, there was a lack of clarity about their role and responsibilities. There was no written protocol which recorded the restrictions to their practice; the nurse responsible for supervising them had not been given instructions as to the scope of their work and the manager of one ward had not had discussions with either the supervisor or the supervisee to ensure they were clear of their role. These nurses wore the same uniform as the other registered nurses and there was

nothing to denote any restrictions on their practice. Whilst one manager told us they did not give out medicines, another said they did under supervision of a registered nurse. Some of the nurses in this position had been working at the trust over four months. They were also recorded on the duty rota as a qualified nurse with "no PIN" written next to their name. This meant there was a lack of clarity for staff and patients about the role of such nurses on the ward. This was brought to the attention of the deputy chief nurse during the inspection.

- The ward managers had 80% of their time budgeted for administration duties which included monitoring the maintenance of records. This time was not protected therefore there were times this did not occur leading to a lack of monitoring of record keeping.
- The demands on the nurses in the acute surgical unit fluctuated due to the nature of the unknown admission rate. Staff reported it could be difficult to have adequate cover; however they used consistent agency staff, when necessary, to ensure the numbers of staff were sufficient to meet the needs of patients. There was a procedure in place to escalate staffing concerns to management.
- On one ward there had been a staff member working in a discharge co-ordinator role. This role had been withdrawn for financial reasons which meant staff with clinical duties also had to manage the discharge of patients, including those with complex needs. This had not been taken into consideration when planning staffing numbers. As a result, one of the nursing staff had other time consuming duties to perform in addition to providing patient care, due to there being no dedicated staff member to make the necessary complex discharge arrangements.
- A shift handover took place at the beginning of each shift. This was comprehensive and the care and treatment of each patient was discussed. Additional to this were multidisciplinary safety huddles throughout the day which consisted of medical ward round updates relating to the ongoing care of patients.

Surgical staffing

- The vacancy rate for medical staff was the lowest it had been since December 2014 at 3.6%. However, there was still a high usage of locum doctors in some specialties. In Ears, Nose and Throat (ENT) 31% of the full time posts in May 2015 were covered by locum and agency staff. In urology, 30% of full time posts had been covered by agency staff. There were additional recruitment procedures in place for both specialities.
- Where possible, locum cover was provided by consistent staff that were familiar with the systems within the hospital.
- If emergency surgery was required out of hours and the staff in the hospital were already operating there was an emergency team on call who could be called in when required. The team included a consultant anaesthetist.
- Patients were not reviewed on a daily basis by a senior surgical staff member following their surgery**.** On those wards which accommodated patients following elective orthopaedic surgery there was no daily ward round due to a shortage of consultant surgeons. An orthopaedic consultant would review patients on these wards should nursing staff feel it was required. Plans for recruitment were underway.
- There was a rota for consultants on the acute surgical unit which meant one doctor worked from Monday to Friday, with a different team covering Friday to Sunday. Staff said whilst the doctors were covering this unit they did not continue with their other duties, or to a much lesser degree. This meant there was consistent cover at the point of admission for quick assessment of patients.

Major incident awareness and training

- Staff we spoke with knew there was a major incident policy and where to find it should it be required.
- Some staff knew their responsibility should a major incident occur, such as what the response would be in their specific area of work, whilst others did not.
- One staff member who had worked at the hospital for over 10 years told us they had never been part of a major incident drill.

Are surgery services effective?

Requires improvement

Evidence was gathered for audit of care and treatment but the outcomes and resulting actions were not known to all relevant staff. Patients' pain was assessed; however the specialist pain team were not available out of hours.

Surgery

Readmission rates were worse than the England average. Following a hip fracture patients were not seen by an ortho-geriatrician within timescales which were in line with national guidance.

Appraisal rates for staff were lower than the trusts' target. Newly appointed nurses had a comprehensive induction. There was effective internal and external multi-disciplinary working. The majority of staff were not clear how the mental capacity of a patient impacted on their role.

Evidence-based care and treatment

- The majority of care and treatment was provided in line with evidence based practice.
- However, the trust employed an ortho-geriatrician consultant to support patients with a fractured neck of femur. This service was available three days per week. There was no availability during weekends or bank holidays. This did not meet with NICE guidance CG124 which states an ortho-geriatric assessment should be available from admission.
- Weekly record checks were performed onwards to monitor compliance. This included early warning scores, safety bundles and cannulation assessments.
- On one ward staff discussed the audits they completed for record keeping and the outcomes and actions taken when the results were poor. On other wards staff were unable to tell us what local audits were done and the resulting actions taken. This meant there was a lack of consistent approach to audit across the surgical services.

Pain relief

- Pre-operative assessments of pain were carried out for all patients. Pain relief was prescribed to ensure there was no delay should a patient require this post operatively.
- Pain relief was reviewed regularly on wards and patients were involved in pain level assessments. We observed that pain relief was offered to patients when they needed it.
- One patient told us how quickly a nurse had responded to their request for pain relief. The doctor had visited to reassess the pain relief being administered and their medicine had been changed with good results.
- There was a dedicated pain team, led by an anaesthetist, who assisted ward staff to support patients with acute pain. This team was not available at weekends or out of hours. The on call anaesthetist provided specialist pain advice out of hours, however this was as part of other clinical responsibilities in theatre. Although there had been no reported incidents, this meant there was the risk of a delay in patients receiving specialist input for their pain relief.

Nutrition and hydration

- Patients who came for surgical procedures were given instructions about food and drink intake before their procedure. We observed that some patients were fasted for longer than recommended as set out in the RCN pre-operative guidelines. For example patients should have been nil by mouth from 6am on the day of their surgery if they were to have their operation in the morning. This included if they were last on the list which was also open to change. This meant that patients could be fasting for five hours prior to surgery which did not meet with the RCN pre-operative fasting guidelines of two hours.
- Patients said the food they had was good, served hot and they had a choice. The food was served from a trolley by ward staff which meant patients could change their choice and request small or large portions.
- The Malnutrition Universal Screening Tool (MUST) was used to monitor patients who were at risk of malnutrition in ward settings. We reviewed care records and found that this tool had been completed, and included appropriate recording of the patient's weight. We found that actions were taken to refer patients to a dietician for specialist advice when required.
- We reviewed nine fluid balance charts and found that only three were fully completed. It was unclear on six fluid balance charts how patients' hydration needs and risks related to dehydration were being monitored.
- Staff on the acute surgical unit identified that patient flow made it difficult to identify how many meals were required throughout the day; however they had changed practice to ensure a choice of food was available at all meal times in order to give admitted patients access to suitable nutrition. Snacks were also available on wards.

Patient outcomes

- Overall the trust was matching the improvement seen nationally in Patient Recorded Outcome Measures (PROMs) and had a lower proportion of patients who reported an outcome worse than they expected compared to the England average.
- In the Hip fracture audit 2014 Royal Lancaster Infirmary scored better than the England average for six of the 10 indicators. However the hip fracture audit data showed the hospital was below the England average for pre-operative assessment by a geriatrician. The England average in 2014 was 51.6% and Royal Lancaster Infirmary was 13.8%. We were told this was due to a lack of consultant geriatricians in the trust.
- In the Lung cancer audit 2014 the trust scored better than or similar to the England average in all three questions.
- The average re-admission rates for trauma and orthopaedics, both elective and non-elective, were above (worse) the England average. This indicator had not previously been monitored by the trust as part of their measure of outcomes for patients. When it had been requested as part of the data collection for this inspection, the trust undertook a retrospective audit using patient records for the three months from April 2015 to June 2015. It was identified that 100 patients were re admitted in that time. The audit found that 76 patients were re-admitted following orthopaedic surgery at the hospital and 21 from the orthopaedic ward
- In the National Laparotomy Audit 2014 (NELA) the Royal Lancaster Infirmary achieved a green rating for six out of 11 measures including: CT reported before surgery, Consultant surgeon present in theatre and consultant anaesthetist present in theatre.
- An action plan had been developed by the trust which included consideration of a rapid review for any patients re-admitted with an infection and a further analysis of 800 patients. Staff on the elective orthopaedic wards were aware that the re-admission rates for patients were high; however they were not aware of the specific numbers or reasons why. Staff were not aware of monitoring arrangements or what action needed to be taken to reduce re-admission rates. In June 2015 the average length of stay trust wide for non-elective admissions was 5.1 days which was only slightly longer than the trust's target of 5 days.
- Some staff on the wards were aware of the audits ongoing in their immediate area such as hand hygiene and mattress audits; however they were unaware of the outcomes or any impact on their own practice. Operating theatre staff and those in specific units such as surgical admissions were not aware of any changes to practice as a result of information from audits. This indicated that whilst practices and performance audits were taking place, the resulting information was not always shared effectively with staff in order to drive improvement.
- Information provided by the trust showed the day case rate in May 2015 was 80.5% which did not reach the trust's target of 84%.

Competent staff

- The trusts' target for appraisal rates was 95%. Information we received showed that it was met in two of four staff groups. Nurses told us their appraisals were useful and resulted in clear objectives being set for them.
- However, in senior nursing staff and medical groups, only one of 17 band 8a and above nurses with responsibility for other staff and 85% of medical staff had completed their appraisal. This meant not all staff were receiving an adequate opportunity to discuss their performance and development on an annual basis.
- The non-medical prescribers in the trust had set up a support group with meetings every three months. This gave them an opportunity to discuss any issues specific to their role and responsibility.
- Staff said the senior nurses, ward managers and matrons were all visible and approachable and they were comfortable to seek assistance if necessary.
- The clinical director told us the revalidation process at the trust was well managed. Reminders for non-compliance were sent to the clinical director for follow up. They said all staff members were revalidated.
- Staff on the surgical wards told us they had one to one supervision on a monthly basis where they could discuss specific issues with their work. They said this was a two way process and they found it supportive.
- Ward managers were unaware of how the forthcoming Nursing and Midwifery Council revalidation scheme was to be implemented in the hospital. Some awareness sessions had been run by the matrons, however not all managers had attended or received information. This meant there was a lack of clarity as to how the competence of qualified nurses was to be adequately revalidated.

- Staff reported good support for their clinical professional development with the ability to take positions as a lead nurse for specific clinical areas and complete additional training if they wished.
- Newly appointed nursing staff said they had good support when they started work from both the other ward staff and the education facilitators. There were clear induction processes for staff which included competency assessments for procedures such as administration of medicines, infection control and discharge of patients.

Multidisciplinary working

- There were trust wide multidisciplinary teams with established links with local speciality teams. For example, head and neck surgery and urology. Meetings took place via video conference and were recorded with the outcome discussed at medical staff meetings and handovers.
- The need for support from professionals such as dieticians was discussed at nurse handover.
- Staff on the wards described good support from physiotherapists and occupational therapists on at least a daily basis. We saw records from the multi-disciplinary team in patient's records so all staff could follow a patient's progress.
- A multidisciplinary complex discharge team was available to assist ward staff to plan for the safe discharge of patients with complex health or social care needs. Staff said this ensured the patient was at the centre of the discharge planning process.
- A multi-disciplinary meeting took place on the orthopaedic ward every morning at 8am. This included physiotherapists and occupational therapists along with the trauma co-ordinators who would discuss each patients care and any planned transfers or discharges.

Seven-day services

- Daily ward rounds took place on all surgical wards in the hospital. This included during weekends when the consultant on call would complete a ward round and contact the consultant if necessary for additional support or advice.
- Operations were performed routinely at weekends in order to reduce the waiting time for patients. This was currently not a full day session with fewer on a Sunday. Theatre staff were not employed to work weekends within their current contracts. . There was acknowledgement this was not sustainable long term and therefore to establish a routine seven day operating service, recruitment would need to include weekend staff. There was currently a trust wide business proposal being developed.
- There was access to a physiotherapy service at the weekends. This was a reduced service with input based on a needs assessment for example specific days following surgery.

Access to information

- Medical and nursing staff said they almost always had the records they required to be able to appropriately care for their patients. The exception to this was the surgical admissions unit where notes were sometimes not available. Lack of complete notes or errors in documentation were reported as incidents 21 times in April and May 2015. On two of these occasions this had resulted in the cancellation of a procedure. This meant staff did not always have access to the records they required. Staff were not clear what action was being taken to improve this issue.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found a varied level of staff understanding of the Mental Capacity Act and the implications for their role and responsibilities. Most staff could not explain when a capacity assessment might be indicated, how it would be requested or who would complete it. This meant that patients may not receive an appropriate assessment of their mental capacity or the support which may be indicated as a result.
- Staff knew how to access guidance regarding the Mental Capacity Act and the deprivation of liberty safeguards on the wards. Some said they had completed e-learning on this subject whilst others said it was part of the safeguarding training. However some of the staff who had undertaken training were not able to explain what their responsibilities were. There was no evidence of separate training about their role and responsibilities with regard to the mental capacity of patients in their care.
- On one ward staff were aware of the process to initiate a deprivation of liberty safeguard referral and when this may be required. However on another ward we observed a patient who had a diagnosis of dementia asking to leave the hospital and there had been no

consideration of the deprivation of liberty safeguards by staff. This showed a lack of clarity by some staff and consistency in the approach to the Deprivation of Liberty Safeguards.
- We looked at three consent forms for surgical procedures which were accurately completed.
- Patients and staff told us the surgical procedure was discussed with them in advance of the surgery taking place. This was discussed at either an outpatient clinic or pre-admission assessment. Written consent was routinely obtained on the day of surgery. The Department of Health "Reference guide to consent for examination or treatment" states: "If a person is not asked to signify their consent until just before the procedure is due to start, at a time when they may be feeling particularly vulnerable, there may be real doubt as to its validity". This meant patients consent was routinely documented immediately prior to the procedure starting which did not meet with best practice.

Are surgery services caring?

Good

Staff within the surgical services were caring. Patients spoke very highly of the attitude of staff describing them as kind, patient and helpful. They said their experience of the hospital was "excellent". Staff attended to patients quickly when they requested assistance and treated them with respect.

Patients said they were involved in their care as much as they required and had been given explanations of procedures and opportunities to ask questions. However, there was a lack of formal emotional and psychological support for patients other than the chaplaincy service.

Compassionate care

- Patients told us the staff were kind, considerate and helpful.
- One patient told us it was the best care they had ever received saying it was "excellent" and they could find nothing wrong at all.
- Staff assisted patients quickly and with patience, showing them respect and protecting their dignity by closing doors and curtains.
- Results of the friends and family test in May 2015 for patients who would recommend the surgical wards were between 86% and 100%. The response rates ranged from 45.8% (ward 34 general surgery) to 85.2% (ward 35 trauma and orthopaedics).

Understanding and involvement of patients and those close to them

- Staff in the pre-operative assessment unit described how they discussed the procedures patients were to have, allowing an appointment time of 45 minutes so they could ask questions and receive the support they may need.
- One patient told us they had been kept informed throughout their stay in the hospital. They had been listened to, were able to ask questions from both the doctors and the nurses, and always got answers.
- The care of the elderly team provided support for older adults and their relatives, specifically around discharge following surgery. This meant additional support was available, including signposting to other agencies, to involve patients and families in safe discharge from hospital.

Emotional support

- Staff said the emotional support for patients would be provided by themselves, the nurse specialists or the chaplaincy service. There was no counselling or psychological support service available for patients. This meant that patients may not receive specific emotional support which may improve their psychological wellbeing following major or traumatic surgery.
- Nurse specialists would provide specific support for patients, for example the stoma nurses following colorectal surgery resulting in a colostomy.
- There were no recorded assessments for anxiety and depression in the files we reviewed. This meant there was no formal way to recognise if a patient required additional emotional support.

Are surgery services responsive?

Requires improvement

There was the possibility for patients to move between hospital sites, if appropriate, to be nearer to family and

friends. Joint working arrangements with other local centres of excellence were in place to improve access and flow. The referral to treatment times for patients admitted to the hospital were worse than the England average; however trust wide initiatives had been launched to reduce these and improvements had been made. There was the facility for patients to be admitted to the acute surgical unit directly following a telephone discussion with their GP and without attending the accident and emergency department. This meant that patients were seen more quickly by doctors from the surgical team.

Surgical procedures were sometimes cancelled at short notice; however procedures were in place to ensure patients were rescheduled as soon as possible (within 28 days). Staff in the surgical admissions department were not aware of any audits in relation to the cancellation of surgery. Data showed the average length of stay for all elective surgery procedures was about the same as the national average and for colorectal surgery was slightly shorter (better) than the average. The average length of stay was only slightly longer (worse) than the national average for elective trauma and orthopaedics and all non-elective procedures.

Services were in place to assist patients with complex needs. Learning from complaints was shared with staff

Service planning and delivery to meet the needs of local people

- There was a specific paediatric operating list which meant children and adults were not together in the recovery area. However there was no specific paediatric recovery area. This meant the recovery area was not supportive of reducing potential anxiety for children when they were recovering from an anaesthetic.
- Where possible adolescents were operated on in the afternoon to prevent them being with adults or children.
- There were flexible visiting times on surgical wards to support patients and visitors, particularly for visitors who had transport difficulties or a distance to travel.
- Following orthopaedic or trauma surgery which may necessitate a longer hospital stay, patients were offered a bed at Westmoreland Hospital in Kendal where possible if it was closer to their family.
- There was a pre-operative assessment unit where comprehensive assessments for patients having elective surgery were completed. There was a triage system to ensure that appointments were given based on patients' needs.
- There was the facility for patients to be admitted to the acute surgical unit directly following a telephone discussion with their GP and without attending accident and emergency. This meant that patients were seen more quickly by doctors from the surgical team.
- Joint working arrangements with local specialist centres for example the cancer specialist centre, meant support would be obtained through multi-disciplinary meetings to ensure where possible the patient did not need to visit hospital sites in another geographical area

Access and flow

- Information provided by the trust showed that in March 2015 all seven of the surgical specialities monitored were not meeting the referral to treatment target of 90% in the admitted pathway. This was in line with the national amnesty on the admitted standard to fail the standard by prioritising the treatment of the longest waiting patients. Orthopaedics had suceeded in treating the greatest proportion of the longest waiting patients at 43.2% against the admitted standard and Oral Surgery the least at 82.8%. Measures had been put in place to further improve this position. These included changes to the waiting list management, use of local independent hospitals, assessing theatre utilisation, re-assigning sessions to increase availability for the longest waiting patients and providing additional operating lists at weekends. This had reduced the number of patients waiting in excess of 18 weeks, across the specialities, from 1091 in January 2015 to 712 in July. However, following this amnesty the trust continued to not meet the referral to treatment target of 90% in the admitted pathway. In April 2015 it was 70%, May 2015: 90%nd June 2015: 77%.
- easures to continue to reduce the waiting times included commissioning additional external private companies to complete procedures, introducing seven day working and utilising the theatres more fully in all three trust sites. Theatre usage had increased in 50% of

the theatres between March and April 2015. There were plans to increase this further and throughout all the theatres; however staff recruitment would need to take place.

- Changes to the management of the waiting list meant those who had been waiting longest were now being offered the quickest appointments. This meant fewer patients were waiting for extended periods.
- Staff told us the operating list for elective day surgery was not "locked down" at any time. This meant it was open to change and patient's allocated time for their surgical procedure could change at short notice. Whilst staff in the surgical admissions unit told us they explained this to patients, they were often not informed of any changes until the porters came to take a patient to the theatres. This meant that patients could not receive accurate information about their waiting time and could impact on their anxiety if they were waiting longer than expected. The majority of complaints in this department were about the waiting times.
- In the surgical admissions unit an ambulatory care area had been developed approximately two months before our inspection. This was used for patients who could sit in chairs or may only need the use of a bed for a short period of time, for example a trial without a catheter. Previously these patients would have been admitted to the day surgery unit. Therefore these patients were only in hospital for a few hours, in a more suitable environment.
- In order to increase the flow of patients through the theatre suite, three recovery bays had been changed into a forward holding area. This meant patients could be brought up from the wards and be ready to go into the theatre area more quickly so reducing the time between patients in theatres.
- In order to reduce cancellations of operations, the operating list numbers were reduced pro-actively during periods which historically had led to cancellations (such as the summer months). This meant fewer patients had their operations cancelled at these times.
- Staff in the surgical admissions department were not aware of any audits in relation to the cancellation of surgery although they did keep the information on the unit. . Data from NHS England showed that from April 2015 to June 2015 there were 92 elective operations cancelled at the last minute for non-clinical reasons. This was in line with the national average. All patients affected were treated within the 28 day timeframe.
- To prevent cancellations of operations where possible patients were offered the opportunity to have their operation at Westmoreland General Hospital.
- NICE guidance states that patients admitted following a hip fracture should be operated on the day of or after admission. Data for 2014 showed, that 70.4% of patients admitted to the Royal Lancaster Infirmary following a hip fracture were operated on the day of or day after admission which was in line with the national average of 71.7%
- There were plans to create a "Trauma stabilization unit" on one ward which would have two bays dedicated to admitting trauma patients pre-operatively. Currently patients that were medically stable and low risk would be admitted to the acute surgical unit. The purpose of the acute surgical unit was to admit surgical patients for assessment by the surgical team, directly from G.P. referral or accident and emergency. Trauma patients, whose needs could potentially be high and may require a longer length of admission, were also admitted to this unit. The trust had identified that the creation of a specialised unit would mean that trauma patients could be nursed together, seen promptly by the relevant doctors and as a result, would not take up beds in the acute surgical unit.
- We were told all junior doctors received training one afternoon per week. At this time the medical cover on the wards was provided by the on-call team. This had resulted in delays particularly with discharges. This issue had not been escalated therefore there were no plans for change or improvement.
- Hospital Episode Statistics data from January 2014 to December 2014 showed the average length of stay for all elective surgery procedures was about the same as the national average and for colorectal surgery was slightly shorter (better) than the average. However, the average length of stay was slightly longer (worse) than the national average for elective trauma and orthopaedics and all non-elective procedures.
- Twelve beds had been opened at Westmorland General Hospital in Kendal for patients needing a longer hospital stay for rehabilitation following orthopaedic surgery, such as a fractured neck of femur. This was identified as beneficial by staff as they were able to make beds available for new patients by transferring patients who were willing, to Kendal.

Meeting people's individual needs

- There was a telephone translation service available for patients whose first language was not English. Staff said this was a fast and efficient service and worked well.
- Staff were aware of the provision of a support "passport" for patients with a learning disability. Where surgery was planned in advance this would form part of the pre-operative care to enable staff to have any necessary adaptations in place.
- There were nurses who had been appointed as dementia champions on the wards. These staff had received additional training and supported other staff to be more aware of the needs of patients living with dementia. However, we identified that there was still work to be done in understanding the potential impact on patient capacity and the mental capacity assessment process.
- A study day was planned to take place in December 2015 for staff who wished to increase their understanding of the needs of patients living with dementia.
- Staff in the pre-operative admissions unit said they could arrange for a tour of the theatres when they were closed, for any patients who may benefit from this due to anxiety before an operation.
- On the general surgical wards, doctors prescribed six doses of anti-sickness medication post operatively. This meant nursing staff could administer this medicine without delay should a patient require it.
- Where a patient's cultural needs, such as religious beliefs, may impact on their safety during surgery we saw a comprehensive discussion about how to reduce risks, whilst respecting their wishes.
- There were two nurses who provided support and advice to staff about caring for older adults on the ward. Whilst this was described as a useful service, some staff identified improvements that would benefit patients such as increased support for older adults following a fractured neck of femur.
- We were told recruitment had taken place to appoint a trust wide nurse lead to provide advice on the care of patients with a learning disability. This role would be responsible for the assessment of the current provision for supporting patients with a learning disability and plan for improvements where necessary.

Learning from complaints and concerns

- Staff on the surgical wards told us they received feedback about lessons learned from complaints during the handover and ward meetings. The majority of complaints received were in relation to waiting times.
- Information posters and leaflets for patients about how to make a complaint was available in various communal locations and on the wards and departments.

Are surgery services well-led?

Requires improvement

Whilst staff knew there was a trust vision, they were unable to give any examples of what it meant for them or their involvement. Staff felt they could discuss concerns with their immediate line managers; however they did not feel their opinions were actively sought. The trust was taking action to address issues around culture and morale within theatres that had been identified in November 2014.The department had a risk register, which identified risks and control measures to mitigate these. Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history.

There was recognition from staff of all grades that the improvement of issues, such as recruitment and operation waiting times had taken over innovative planning for the future of the surgical services.

Vision and strategy for this service

- We asked seven staff members from different departments and of varied grades if they were aware of the vision for the organisation. Whilst they knew there was a trust vision, they were unable to give any examples of what it meant for them or their involvement.
- Staff we spoke with were able to explain future plans related to increasing activity especially in elective surgery as they were aware of the long waiting times which had been an issue for the trust.

Governance, risk management and quality measurement

- A weekly meeting took place, chaired by the executive chief nurse to discuss any shortfalls in harm free care

such as pressure ulcers, falls and infections. This included lessons learnt and any changes to practice required as a result. The ward managers then cascaded this information during the ward meetings and handovers to their staff.

- The risk register for surgery was incorporated as part of the divisional risk register for the surgery and critical care division. The main risks identified for surgery services related to staffing, delivery of service within budget, failure to achieve the 18 week referral to treatment standard and management of patient falls. Action points with progress made were documented. However, the actions detailed had not so far reduced the on-going risk rating on the risk register. The risks were not dated so it was not clear how long they had been on the risk register. Managers we spoke with were aware of the highest risks identified.
- The department had a risk register, which identified risks and control measures to mitigate these. Risk register reports provided by the trust did not include details of actions taken to mitigate risk. However, the trust told us they use a live electronic risk register that includes all mitigating actions, status and progress history.
- The quality assurance matron had been appointed to the trust wide corporate governance team. They told us they had spent at least two days per week at the Royal Lancaster Infirmary site to discuss the quality of care provided, with particular focus on the ward accreditation scheme. This had been based on similar schemes in other hospitals the trust had visited. The scheme involved rated quality assessments which led to an overall accreditation for wards that maintained the highest standard for three consecutive assessments. The specific assessments were designed to encourage team work as they included various care and support themes. This showed a focus on continued quality improvement.

Leadership of service

- Staff said the matron for the surgical wards was approachable and supportive. They were visible on the ward by visiting every morning.
- Nursing staff attended ward meetings where general issues were discussed, such as incidents, and training and governance information was shared. The minutes were distributed and all staff were expected to read and sign their understanding of the minutes.
- It had been recognised through discussions with staff that some grades would benefit from leadership training. An external trainer was being used and 120 band 6 and 7 nurses across the trust had completed this training. A member of staff who had completed the training said it had helped their understanding of the management of services and staff and working as a team.
- Additional leadership posts planned in the surgical services included a matron for theatres who would work across all the trust sites. This was seen as a very positive move by all the theatre staff we spoke with, who said it would increase the visibility of the trust wide management team for them. This post had been created as a direct result of a review of the theatre working at the trust.

Culture within the service

- Theatre managers discussed how there had been a disrespectful culture between staff members which had led to staff raising issues of bullying and lack of dignity at work. This had been investigated in November 2014 with all theatre nursing and medical staff completing a Health and Safety Executive survey. An action plan had been developed from the themes which included: workshops being held for every staff grade, a review of job descriptions, a review of the rostering of staff, monitoring of sickness and absence management, introduction of face to face exit interviews and increased methods of communications. One to one support was offered to staff and staff groups were set up with regular fortnightly meetings.
- We were told by one manager that staff had not been re-surveyed; however another told us this was done in March 2015 due to a recurrence of concerns being raised. The results of this were poor and showed a continuation of low morale. Further measures for improvement included the employment of a matron for theatres and support from an outside agency commencing in August 2015 for six weeks. We were advised that a further survey to monitor progress would take place following these actions.
- Staff in theatres knew of the measures in place to improve the culture; however some felt there were some working practices that had not been well managed, such as the changes to working patterns.

Public engagement

- A questionnaire was given to patients for completion prior to discharge. This asked patients their opinion of the quality of care they had received including the cleanliness of the environment and meals. The information was used, by the ward managers, to inform staff of how well they were performing.
- Informal feedback was sought by staff on the wards and we saw staff ask patients for their opinions about the care and treatment received.

Staff engagement

- Following the issues related to the culture in theatre, "respect champions" had been introduced. These were staff members who volunteered to be a voice to listen to the other staff. This was a cross divisional initiative and posters were used to inform other staff throughout the hospital.
- Staff told us there had been no staff survey or any other way of the trust management proactively seeking their views.

Innovation, improvement and sustainability

- Staff were working to continually improve the care and treatment for patients in their individual working areas. There were some fundamental standards which staff were aware needed to be improved, such as the recruitment of permanent staff. This took precedence over innovation as there was recognition this needed to be addressed first.

Critical care

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	Requires improvement

Information about the service

The critical care unit at the Royal Lancaster Infirmary was commissioned to provide eight beds in total, six level 3 and two level 2 beds, which were used flexibly as the service demanded. We were informed that on occasions the unit had accommodated eight level 3 patients. The facility included two side rooms, which were used for the isolation of patients identified as being an increased infection control risk. ICNARC data indicates that the unit has around 500 admissions per year. At the time of our inspection the unit was full. For the purposes of governance the unit sat in the surgical and critical care division.

During the inspection we spoke with two medical staff, seven members of the nursing team, two patients and four sets of relatives. We also reviewed patient records, policies, guidance and audit documentation.

Summary of findings

Following the last inspection in February 2014, we found that overall the critical care service provided at the Royal Lancashire Infirmary was good.

However, at this inspection we have judged that the critical care service required improvement particularly in the areas of safety and responsiveness. There were sufficient numbers of suitably skilled nursing staff to care for the patients. However, there was no commissioned supernumerary nurse on duty and the unit did not have any funded practice educators in post. There was access to a consultant and middle grade anaesthetist at all times although out of hours the on call anaesthetist had responsibilities for other specialities, such as maternity. We found that drugs and intravenous fluids were not always stored securely.

When people required intensive care there were no significant delays in that care being delivered, however, there was often a delay in discharging patients once they had been judged as medically fit for discharge. This often also resulted in a breach of the Department of Health's single sex accommodation standard. The clinical area had limited space and fell short of the most recent health building note specifications (HBN-04-02) in relation to infection control isolation rooms. There were no clearly defined plans available for how this shortfall was to be addressed. Additionally there were occasions when owing to capacity and bed availability, patients requiring critical care were looked after in the theatre recovery area.

Critical care

The unit continued to collect and submit data for the intensive care national audit and research centre (ICNARC) for validation, so it was able to benchmark its performance against comparable units. This data showed that patient outcomes were within the expected ranges when compared with similar units nationally. Critical care services were being delivered by caring, compassionate and committed staff. We saw patients, their relatives and friends being treated with dignity and respect. The unit did not provide a formally commissioned outreach service. There were robust systems and processes in place for reporting incidents and there was evidence that learning from incidents was disseminated.

Are critical care services safe?

Requires improvement

There were sufficient numbers of suitably skilled nursing staff to care for patients. However, there was no commissioned supernumerary nurse on duty and the unit did not have any funded practice educators in post. There was access to a consultant and middle grade anaesthetist at all times although out of hours the on call anaesthetist had responsibilities for other specialities, such as maternity.

At the time of inspection we found that not all drugs were securely locked away. Intra-venous fluids were stored in open drawers and potassium pre-filled syringes were kept in the fridge which wasn't locked. The clinical area, whilst functional, was dated and had limited space. The unit did not meet the requirements of the most recent health building note specifications (HBN-04-02) in relation to infection control isolation rooms. We were informed by the trust that any any upgrade will meet the latest HBN and other standards. The Estates Strategy approved by Trust Board in March 2015 included the remodelling of the whole ICU to occupy twice its present floor area. This was subject to capital finance being provided.

Not all the medical and nursing records that we examined had entries that were dated, signed and indicated the author's GMC or NMC (professional registration) number.

Incidents

- Incidents were reported via an electronic system; all the staff we spoke with were familiar with the system.
- All incidents were reviewed and their details collated and presented at the weekly divisional management meeting/patient safety summit and the monthly divisional governance meeting. This enabled emerging trends to be monitored and the effectiveness of interventions tracked. For example, the minutes for the April 2015 divisional governance and assurance group meeting (DGAG) reported that there had been 55 needlestick/sharps incidents for the year 2013/14. The report stated that the number for 2014/2015 was 41. Initiatives had included a focus on reminding staff to use eye protection thus reducing the number of splashback incidents reported.

- We saw a range of methods used to share learning both trust wide and within the unit. These included newsletters, patient safety group and staff meetings and shift handover notes.
- Mortality and morbidity discussions were held at a number of meetings, at least monthly and it was the role of the divisional governance lead to ensure that learning was shared within the division. Links between mortality and the quality of care provided in hospitals has been shown to have an inverse correlation; the higher the mortality, the lower the quality of care. The trust held a quarterly mortality and morbidity review meeting in order to monitor consistency of approach to divisional management of mortality and morbidity.
- Staff understood the concept of 'duty of candour' and reference was made to duty of candour discussions with patients and their families in the actions sections of the risk register. The aim of the duty of candour regulation is to ensure trusts are open and transparent with people who use services and inform and apologise to them when things go wrong with their care and treatment.

Safety thermometer

- There were clear 'Safety Thermometer' performance boards displayed in the corridor outside the critical care unit, which showed current performance. These provided a quick and simple method for surveying patient safety and analysing results in order to measure and monitor improvement. However, the data presented was not always easy to interpret. For example, family and friends data for June 2015 was reported as 4.73% out of 5. The cleanliness was reported as '5' without any explanation as to what this score meant.
- The performance boards showed the current results in respect of falls, pressure ulcers, catheter acquired urinary infections (CAUTIs) and venous thromboembolism (VTE). The data showed that for June 2015 there had been no falls on the unit and no incidences of Clostridium difficile or methicillin resistant staphylococcus aureus (MRSA). From March 2014 to March 2015 there had been a low number of falls and CAUTIs. There were 16 pressure ulcers in the same reporting period with a sharp increase in prevalence from July to August 2014. However there had been none reported since December 2014.

Cleanliness, infection control and hygiene

- The trust had infection prevention and control policies in place which were accessible to staff.
- Hand hygiene audits and compliance with aseptic non touch techniques (ANTT) were audited monthly and the results produced both graphically and numerically to show performance against trajectory. (Aseptic technique is a procedure used by clinical staff to help prevent the spread of infection). For the year 2014/2015, hand hygiene competency was measured overall at 88% against a trajectory of 90%. For ANTT, the overall average competency for the same period was 82% against the trajectory of 90%. There were associated action plans in place which included on-going monitoring of the scores against trajectory. (It should be noted that these figures represent performance across the surgery and critical care division).
- Personal protective equipment was available for staff and we saw it being used appropriately. Staff adhered to the 'bare below the elbows' policy that was in place. There were sufficient hand washing facilities and antiseptic gels available.
- Fabric bed side curtains were being used that were generally changed every six months. We were informed that there was an intention to move to disposable curtains but no date had yet been set for this change.
- According to the submitted and verified intensive care national audit and research centre data (ICNARC), the unit performed as well and sometimes better than similar units for unit acquired methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile infection rates.
- There were appropriate arrangements in place for the safe disposal of sharps and contaminated items.
- We noted that the commodes were clean and displayed a green "I am clean" sticker to indicate that they had been checked and cleaned.

Environment and equipment

- The main clinical area held eight patient bays, two of which were housed in side rooms. The side rooms did not have double doors with an air lock or have the facility for positive or negative pressure air flows. This shortfall potentially compromised the effectiveness of infection control measures. On the day of inspection the patients in the two side rooms did not present an infection control risk so the doors were being left open.
- The environment did not meet the requirements of the latest building specifications (HBN -04-02) . For example,

with reference to the aforementioned isolation rooms, HBN 04-02 states that 'single bed rooms with lobbies are required for the isolation of patients to control the spread of infection or for the protection of immuno-suppressed patients' and 'the ventilation system should be designed to provide simultaneous source and protective isolation. A balanced supply and extract ventilation to each isolation and gowning lobby is proposed. The lobby, which functions as an air lock, requires a relatively high and balanced supply and extract air change rate to be effective against airborne organisms moving between circulation areas and isolation rooms'. We were informed by the trust that any upgrade will meet the latest HBN and other standards. The Estates Strategy approved by Trust Board in March 2015 included the remodelling of the whole ICU to occupy twice its present floor area. This was subject to capital finance being provided.

- We saw resuscitation equipment, including defibrillators and difficult airway management trolleys that were all checked daily.
- Each bed space was capable of managing a level 3 patient.

Medicines

- Allergies were clearly documented in the prescription records that we looked at.
- Medicines were not kept in a separate room but in an open plan area to the side of the nurse's station.
- Controlled drugs were stored in a locked double cupboard, with the keys held by any of the registered nurses on duty. We were told that the stocks were reconciled daily by the night staff and not on handover between the shifts.
- At the time of inspection we found that not all drugs were securely locked away. Intra-venous fluids were stored in open drawers and potassium pre-filled syringes were kept in the fridge which wasn't locked, alongside various muscle relaxant injections. Records showed the temperature of the fridge was being monitored to ensure it stayed within the recommended range.
- Boxes of fluids were also stored on the floor.
- We took the opportunity to speak with the unit pharmacist who agreed there were drug storage issues on the unit. However it was not clear what plans there were to resolve the secure storage issues.

Records

- The unit used paper based records, which were completed by the multi-disciplinary team. They contained a range of risk assessments and care bundles which were mostly completed, legible and up to date. For example, pressure sore scoring tools and delirium risks. However, not all entries in the nursing and medical notes were dated, signed and indicated the author's GMC or NMC (professional registration) number. In some cases we saw that the staff member used a stamp alongside their signature, which gave the required detail, though the use of a stamp was inconsistent.
- Physiological observations and prompts for care and treatment were appropriately recorded on a large intensive care record sheet at the foot of the bed space.

Safeguarding

- There was an internal system for raising safeguarding concerns and staff were aware of the process and could explain what constituted abuse and neglect.
- Safeguarding training formed part of the unit's mandatory training programme. We saw that staff received safeguarding training for both adults and children.
- At the time of inspection, records showed that 99% of staff had received level 1 training in safeguarding adults, with a further 85% having completed level 2. With regard to children's safeguarding training, again 99% had completed level 1 and 85% had completed level 2.

Mandatory training

- Records of mandatory training completion were kept and continuously updated. These were reviewed and reported on at the monthly DGAG meeting.
- Training was identified as a risk and was on the divisional risk register along with a series of actions being implemented to mitigate the risk. For example, an increase in the number of key trainers.
- The training topics with the worst levels of completion were for conflict resolution (61%) and moving and handling module D (40%). Other areas demonstrated a much higher completion percentage such as equality and diversity (99%), health, safety and welfare (99%) and infection, prevention and control (99%). Resuscitation

training recorded an overall completion figure of 80% though the data showed a lower number of medical staff had completed basic life support training as opposed to nursing staff.

Assessing and responding to patient risk

- The unit did not provide any formal critical care outreach. However, staff told us that wherever possible they did visit and review patients within 36 hours of their discharge from the unit.
- The ward areas used a physiological observation track and trigger tool (POTTS). This chart was designed to collect routinely charted vital signs and observations alongside an integrated early warning system.
- We spoke with members of the resuscitation team who told us that the hospital contributed to the national cardiac arrest audit. They also reported a weekly audit of POTTS charts, which showed a reduction in cardiac arrests of 30% across all three trusts sites in the January to March 2015 period. A number of associated initiatives were also cited as contributing to this reduction such as absolute minimum four hourly observations and the introduction of manual sphygmomanometers (equipment used to measure a person's blood pressure) in ward bed areas.
- Patient's records contained a range of clinical risk assessments. For example, venous thromboembolism, moving and handling and visual infusion phlebitis (VIP) assessments.
- Staff told us that there were, on occasions, delays in getting out of hours medical assistance as the on call doctors had to cover other areas within the hospital and the nursing staff did not have advanced life support training. This issue did not appear on the divisional risk register and staff could not actually recall an incident resulting in sub optimal care as a consequence of any delay in receiving medical assistance.

Nursing staffing

- The Intensive Care Society standard for patient acuity was used to determine the number of staff required.
- On the day of inspection there were adequate numbers of suitably skilled and qualified nursing staff on duty to ensure that people received safe care and treatment. The unit was full with eight patients in residence. There was one planned admission and a bed became available once the patients had been formally reviewed by the medical staff.
- However, when the unit was at full capacity, patients were sometimes cared for in the theatre recovery area. We were told by staff that on such occasions they struggled to find enough appropriately qualified nursing staff and on occasions band 5 nurses had to manage more than one level 3 patient. Records showed that this had occurred 46 times in the period July 2014 to June 2015. This is in contravention of the Intensive Care Society standard for nurse staffing that requires a minimum registered nurse/patient ratio of 1:1. Not meeting this standard meant that care provided to level 3 patients could be unsafe.
- The unit was not funded to provide a supernumerary clinical co-ordinator (band 6/7) on duty 24 hours a day as per the Intensive Care Society standards. However, we were given information which indicated that for 91% of the actual shifts there was in fact a supernumerary clinical leader on shift. On the day of inspection this was made possible as the two ward managers where able to assist clinically on the unit.
- The trained nurses were supported on shift by both clinical and non-clinical support workers.
- There were no funded practice educator posts within the unit's nursing establishment. These posts are used to co-ordinate the education, training and continuous professional development framework for critical care nurses.
- There were two shift handovers per day and in addition a sister to sister handover took place to include any non-clinical issues.
- Agency nursing staff were rarely used. Any additional shifts were put out to the existing and/or bank staff in the first instance. A text reminder service was used to quickly inform staff of available shifts.
- Additional staff were often needed when capacity meant that patients were looked after in theatre recovery. These occasions were always raised as a moderate incident and records showed that this had happened 46 times since July 2014. An average of almost once every week.
- We were told there were no plans to develop the advanced nurse practitioner role.

Medical staffing

- The unit operated with a named consultant for a period of 24 hours. The consultant responsible for the unit then changed each day. This arrangement does not lend itself to the same levels of continuity that having a consultant on for five days would provide.
- We were informed that all consultants working in the unit were fellows or associate fellows of the faculty of intensive care medicine.
- Consultant to patient ratio was normally no more than 1:8 which is in accordance with the Intensive Care Society standard.
- The consultant was supported during the day (up until 8pm) by a trainee (Core Trainee 2 or above).
- There was a consultant to consultant handover at 1pm each day though this was not always a written handover. The trainees would also handover at 1pm and 8pm. Again this was not always documented.
- Out of hours there was a consultant on call. The first on call, out of hours, was a member of the anaesthetic team who also had responsibilities for other areas in the hospital such as maternity. This could potentially result in a delay in an intensive care patient receiving treatment, though was not identified as a risk on the divisional risk register (April 2015). A third trainee doctor was also on call for the management of any out of hospital patient transfers.

Major incident awareness and training

- Major incident and business continuity policies and protocols were in place and readily available.
- We did not see any evidence to demonstrate that the major incident plan had been practised.

Are critical care services effective?

Good

The unit continued to collect and submit data for the intensive care national audit and research centre (ICNARC) for validation, so it was able to benchmark its performance against comparable units. This data showed that patient outcomes were generally within the expected ranges when compared with similar units nationally. The exception being for delayed discharges where the unit's performance was slightly worse than the England average. Care was delivered in line with evidence- based, best practice guidance, such as NICE guidance. There was a commitment to clinical audit and evaluation.

The trust was also part of the Lancashire and South Cumbria Critical Care Network and so worked with other stakeholders (acute trusts and clinical commissioning groups) with a commitment to sharing and promoting best practice in critical care services.

Evidence-based care and treatment

- The unit used a combination of national and best practice guidance to determine the care they delivered. These included guidance from the Intensive Care Society and the National Institute for Health and Care Excellence (NICE).
- The unit demonstrated continuous patient data contributions to the intensive care national audit and research centre (ICNARC). This meant the care delivered and mortality outcomes for patients were benchmarked against similar units nationally.
- The unit was also subject to an annual peer review by the Lancashire and South Cumbria Critical Care Network (LSCCCN). The purpose of the review was to demonstrate evidence at unit level of the range of standards applicable to critical care as outlined in their service specification.
- Following the last LSCCCN review in November 2014, it was recommended that the unit required a rehabilitation lead to facilitate the effective development and implementation of rehabilitation documents, such as NICE CG 83 Rehabilitation after Critical Illness and NICE CG 103 Delirium. It was not clear if this recommendation had been implemented.
- The unit participated in a range of national audits such as ICNARC, ICBIS (adult critical care transport audit) and the national cardiac arrest audit.
- There was a trust wide and departmental audit programme. The unit had a quality improvement lead (QIL) in post. Additional responsibilities for the band 6 clinical leaders in post were overseeing the audit programme and looking at service improvements. Audit activity included the weekly collection of high impact intervention data that was sent to the LSCCCN. Reports and lessons learned were then shared by the network. For example, the unit had been able to introduce a sling

technique for the securing of naso-gastric tubes which had reduced the number of related pressure ulcers. Another aspect of the QIL role was the oversight and reviewing of policies.
- There was a range of local policies, procedures and standard operating protocols in place which were easily accessible via the trust wide intranet.

Pain relief

- There was access to the pain management team for support and guidance during the week.
- As part of their individual care plan all patients in critical care were assessed in respect of their pain management. This included observing for the signs and symptoms of pain. Staff utilised a pain scoring tool and analgesic ladder.
- We saw that epidurals and patient controlled analgesia systems were used in accordance with trust guidelines.

Nutrition and hydration

- Guidelines were in place for initiating nutritional support for all patients on admission to ensure adequate nutrition and hydration. Nutritional assessments were undertaken within six hours of admission.
- Nutritional risk scores were updated and recorded appropriately in the patients' notes.
- There was strict fluid balance monitoring for patients, which included hourly and daily totals of input and output.
- The unit had access to a dietetic service during the week although there was no dietetic service available during the weekend.

Patient outcomes

- The results from ICNARC showed that patient outcomes and mortality were within the expected ranges when compared with similar units nationally.
- The most recently verified ICNARC data that we saw (for the period April 2013 to March 2014) showed the following outcomes:
  - Hospital mortality was slightly worse than the England average although still within the expected range.
  - The figures for unit acquired MRSA and infections in blood were in line with the England average.
  - The number of unplanned readmissions to the unit within 48 hours was better than the England average.
- However, ICNARC data for the same period showed the hospital performed worse than the England average for 'Delayed discharges (12 hour delay)' and 'Delayed discharges (24 hour delay)'.
- The unit did not provide a formal outreach service for its patients though did endeavour to visit all discharged patients within 36 hours, providing they remained in hospital at that point. Minutes of the cross bay critical care delivery group meetings showed that the percentage of patients that were transferred from critical care but were still in hospital after 36 hours had increased from 30% in February 2015 to 71% in May 2015. This had an impact on the unit staff to make sure they were able to follow up their discharged patients in a timely manner.
- At the time of the inspection there were no outlying critical care patients. However, during the period July 2014 to June 2015 there had been 46 patients managed in the theatre recovery as an overflow from critical care. The trust was undertaking some work going back to 2009 to better understand the implications for all involved when patients ended up staying in recovery for longer than was planned. The current trust critical care admission, discharge and operational policy stated that: 'ventilation of patients in recovery should only be undertaken in exceptional circumstances'.

Competent staff

- The unit did not have a practice development/educator in place to support staff and facilitate bed side teaching.
- Nursing staff received an annual appraisal. By March 2015, divisional records showed that 88% of nursing staff (bands 1-7) had received an appraisal in the last 12 months. The figure for band 8a upwards was also 88%. Trainee medical staff stated that they were well supported and had an appraisal and revalidation process in place with good opportunities for training. The March 2015 divisional figures showed that 86% of medical staff had received an appraisal in the last 12 months.
- All nursing staff were subject to an annual check of their registration with the Nursing and Midwifery Council.
- We saw that 53% of the registered nurses working on the unit had a post registration qualification in critical care. This was due to increase to 64% as five staff were due to start the course in September 2015.

- Nursing staff had completed intermediate life support (ILS) training but not advanced life support training (ALS). Nursing staff had also completed training in paediatric life support.
- New staff to the unit were given a period of four weeks supernumerary status and were given the critical care 'step 1' competencies to work through. Step 1 competencies have been designed to provide the core competencies required to look after an adult critical care patient. This falls short of the six weeks as a minimum supernumerary status recommended by the intensive care society.

Multidisciplinary working

- Multi-disciplinary ward rounds took place each day that involved medical, nursing and pharmacy representation. We were told that the physiotherapists did not attend the ward round but had a handover from the nursing staff when they attended, which was twice a day, seven days a week.
- Both nursing and medical staff described that there was 'good' multi-disciplinary working on the unit. Though we also heard that there was, at times, pressure on the unit, from senior managers to take patients when it would mean the overall patient acuity was then greater than the numbers of staff available to care for them in accordance with the desired nurse: patient ratio.
- The critical care admission, discharge and operational policy detailed a number of multi-disciplinary arrangements both internal and external for the management of their patients. These included the frequency of parent team reviews and for the transfer of patients both within the LSCCCN and beyond to the wider networks should this be required.

Seven-day services

- A consultant anaesthetist/intensivist was available seven days a week including out of hours.
- Dietetic and pharmacy services were available Monday to Friday and via on-call at weekends. The physiotherapy team provided a seven day a week service to the critical care unit.
- Imaging and diagnostic services were provided during the working week and then via on-call out of hours and at the weekend.

Access to information

- The critical care unit used a paper based record system which was accessible at the patient's bedside. This enabled consistency and continuity of record keeping whilst the patient was on the unit, supporting staff to deliver effective care.
- When a patient was discharged to the ward a transfer document was printed, which formed the basis for the nurse to nurse handover. The handover was undertaken face to face once the patient had been settled into their ward bed space.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Staff demonstrated an understanding of the issues around consent and capacity for patients in critical care. Staff did articulate that if they were unsure in any circumstances they would seek guidance from senior staff or from the safeguarding lead.
- Training in mental capacity was provided on-line.
- There was an assessment of delirium recorded in the patient record daily. This was called the confusion assessment method for ICU or 'CAM-ICU'.

Are critical care services caring?

Good

Critical care services were delivered by caring, compassionate and committed staff. We saw patients, their relatives and friends being treated with dignity and respect. The care being delivered was patient focussed, taking their wishes into account. Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.

Since the last inspection the unit was trialling the use of patient diaries, where appropriate, in specific bed areas to help people come to terms with their critical illness experience. Follow up clinics were offered to patients two to three months after discharge from critical care when they had experienced an extended stay or been subject to artificial ventilation. This attendance included psychology input.

Compassionate care

- Staff took the time to interact with people being cared for on the unit and those close to them in a respectful and considerate manner.
- We noted that staff were encouraging, sensitive and supportive in their attitude.
- People's privacy and dignity was maintained during episodes of physical or intimate care. Curtains were drawn around people with appropriate explanations given prior to care being delivered.
- We were informed of a recent case where the staff had facilitated the marriage of one of the patients whilst they were on the unit.

Understanding and involvement of patients and those close to them

- Staff communicated with people so that where possible they understood their care and treatment. This was corroborated by the two patients that we were able to speak with during the inspection.
- We spoke with the relatives of four patients on the unit. They were universal in their praise for the medical and nursing staff. Reporting that they had been kept informed of everything that was going on with their relative.
- Initial and on-going face to face meetings were implemented by nursing and medical staff to keep people informed about their relative's care and treatment plans.
- Since the last inspection the unit was trialling the use of patient diaries, where appropriate, in specific bed areas. Intensive care patient diaries are a simple but valuable tool in helping people come to terms with their critical illness experience. The diary is written for the patient by healthcare staff, family and friends. Research has shown that patient diaries often help the patient better understand and make sense of their time in critical care and help to prevent depression, anxiety and post-traumatic stress.

Emotional support

- Staff demonstrated that they understood the impact of critical care interventions on people and their families both emotionally and socially.
- There was a senior nurse for organ donation who worked closely with the critical care team in managing the sensitive issues relating to approaching families to discuss the possibilities of organ donation.
- Follow up clinics were offered to patients two to three months after discharge from critical care when they had experienced an extended stay or been subject to artificial ventilation. This attendance included psychology input.

Are critical care services responsive?

Requires improvement

From February to June 2015 there had been 112 reported delayed discharges from critical care. In 109 of these cases the cause was reported as being due to a lack of a ward bed. In the other three cases a side room was specifically needed. Remaining in a critical care environment when it is no longer required can be stressful for patients. Furthermore, when patients experienced a delayed discharge then the unit was unable to provide single sex accommodation and breaches of the standard did occur.

At times the demand for critical care beds outstripped the availability and the unit had moved critical care patients to theatre recovery to be cared for (also known as outliers). This situation put additional pressure on the skills required to then look after that patient in recovery. If a critical care nurse moved with the patient that then diluted the skill mix back on the critical care unit itself. There had been occasions when a patient had been booked in for surgery and needed a level 2 bed that had subsequently not been available. The patient had then had to be discharged to the ward post-operatively. Again this had an impact on the ward staff and their competencies to care for such a high dependency patient.

The above issues were known to the trust and were identified in the division's strategy, with actions being taken to address this identified shortfall.

Service planning and delivery to meet the needs of local people

- There were a number of structured bed management meetings throughout the day. These were attended by representatives from all the specialties including critical care. The meetings gave an overview of the bed management situation within the trust. Up to date access and patient flow information within the trust was discussed. Details about staffing levels were included as were planned patient admissions and the number of

beds available. At the time of our inspection the critical care unit was full and a bed was found for the one patient who was ready for discharge to the ward that day.
- When patients experienced a delayed discharge then the unit was unable to provide single sex accommodation and breaches of the standard did occur.
- We were told that work was being undertaken to try and better understand the need for critical care beds across the network. There was a feeling amongst staff that more critical care beds especially at level 2 were needed.

Meeting people's individual needs

- Patients were being reviewed in person by a consultant within 12 hours of their admission.
- Care plans demonstrated that peoples' individual needs were taken into consideration before delivering care.
- Interpreting services were available within the hospital if required.
- There were facilities for relatives to stay on the unit if they wished to.
- Once discharged from critical care there was no formal outreach service provided. The unit was often contacted by ward staff for advice about patient management and the staff had started to record details of how often this occurred.

Access and flow

- The critical care unit had a clear written operational policy for admission and discharge.
- From February to June 2015 there had been 112 reported delayed discharges from critical care. This represented 23% of all admissions or almost one in four patients who had their discharge delayed.
- From July 2014 to June 2015, 46 critical care patients had been cared for in theatre recovery. This meant there had been 46 occasions when there was no bed in critical care and the occupancy rate had been 100%. It is recognised that bed occupancy levels in critical care greater than 85% can have an adverse effect upon the care provided.
- The most recently validated ICNARC data for the period April 2013 to March 2014 showed that
  - For non-clinical transfers, the unit performed about the same as other similar units in England.
  - For out of hours and delayed discharges the unit performed worse than similar units in England.
  - The performance of the critical care units across the Morecambe Bay area was monitored closely by the critical care delivery group that met monthly.

Learning from complaints and concerns

- Staff were aware of the trust complaints policies and processes and any complaints were handled in accordance with trust policy.
- At the entrance to the critical care unit there was information for relatives and visitors about the patient, advice and liaison service (PALS) along with a relatives' questionnaire.
- Also displayed at the entrance to the unit were examples of the 'you said…we did…' initiative. For example, the dieticians were looking into the availability and selection of gluten free foods in response to a suggestion from relatives.
- The unit reported very few complaints and had not received a formal complaint since the last inspection.

Are critical care services well-led?

Good

There had been significant changes to the leadership and structure of the division during the past 12 months, which were now starting to embed. For example, the formation of clinical business units. The divisional strategy aimed to empower its staff through an on-going commitment to engagement and leadership development.

There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements. We saw committed and capable clinical leaders and managers at unit and divisional level who had a clear understanding of the risks to the service. The risk register identified the key risks within the service and the actions taken to mitigate them. However, actions taken so far had not reduced the on-going risk ratings on the risk register.

Vision and strategy for this service

- The surgical and critical care division presented a five year strategy which was aligned with the wider trust

principles of people, patients, promotion, performance, partnerships and premises. Many of the shortfalls we identified relating to staffing in critical care and the premises were addressed in the strategic plan.
- The unit had a named clinical director whose main role was to manage and plan how services were delivered and contribute to the process of strategic planning, influencing and responding to organisational priorities.

Governance, risk management and quality measurement

- The service measured itself against both the Intensive Care Society core standards and the Lancashire and South Cumbria Critical Care Network service specifications. The unit was subject to annual peer review benchmarking against the present evidence base and agreed standards for critical care provision.
- There was an effective governance structure in place which ensured that all risks to the service were captured and discussed. The framework also enabled the dissemination of shared learning and service improvements.
- The risk register for critical care was incorporated into the divisional risk register along with surgery. The top critical care risks recorded related to delayed discharges from critical care, the risk related to patient transfer outside the hospital, lack of critical care outreach and gaps in resuscitation training. The risk register outlined actions (both taken and planned) to reduce the aforementioned risks. Though, the actions detailed had not so far reduced the on-going risk rating on the risk register.

Leadership of service

- There had been significant changes to the leadership and structure of the division during the past 12 months, which were now starting to embed. For example, the formation of clinical business units.
- We saw that senior medical and nurse leaders were committed to providing a safe service for their patients.
- The critical care unit had a designated consultant clinical lead and the nursing team was enthusiastically led by a team of experienced ward managers and clinical leaders.

Culture within the service

- Staff were encouraged to report incidents and raise concerns.
- Staff were open, honest and happy to tell us what it was like to work in critical care.
- There was evidence of collaborative working and positive relationships with other departments within the hospital.

Public engagement

- The trust website had very little information about the critical care service. Interestingly it listed the telephone number for the 'intensive therapy unit' at Royal Lancaster Infirmary but called the unit at Furness General Hospital in Barrow, the 'intensive care unit'. It was not clear why the two units had different names.

Staff engagement

- The aforementioned divisional strategy reported that under its 'people' principle it aimed to empower its staff. One of the ways in which it aimed to do this was by an on-going commitment to engagement and leadership development. The hope was that the initiatives planned would provide career development opportunities and assist in staff retention.
- We saw examples of a number of 'listening into action' (Lia) projects. Lia is about re-engaging with staff and unlocking their potential so that they can contribute to organisational success. For example the whole issue of 'outliers' in critical care was part of a Lia scheme of work sponsored by the medical director. Several short term interventions, such as the education of theatre recovery staff in step one critical care competencies, were taking place to help mitigate the risks whilst a wider review of critical care provision took place.
- Staff told us that they felt better engaged with managers in the trust and that they had an opportunity to express their views.

Innovation, improvement and sustainability

- The ICU was an active member of the Lancashire and South Cumbria Critical Care Network. Membership of the network enabled the unit through collaborative working with commissioners, providers and users of critical care to focus on making improvements where they were required.

Maternity and gynaecology

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Royal Lancaster Infirmary (RLI) offers a range of gynaecology services as well as midwife-led and obstetric consultant-led care for high risk and low risk women.

There are 24 maternity beds and 10 gynaecology beds, a labour ward, an early pregnancy assessment unit and day assessment unit. The central delivery suite had seven delivery rooms (including a birthing pool room), one dedicated maternity theatre and one gynaecology theatre which was larger and so used for multiple deliveries if required.

Between June 2014 and June 2015, there were 2,139 births at RLI. The percentage of births to mothers aged 20-34 was slightly higher than the England average. The percentage of births to mothers aged 20 and under was the same as the national average.

During our inspection, we visited the antenatal clinic areas, antenatal and postnatal ward, labour ward and early pregnancy assessment unit. We spoke with 11 patients and 43 staff, which included: midwives, ward sisters and managers, matrons, doctors, consultants, senior managers and support staff. We observed care and treatment and looked at seven care records. We also reviewed the trust's performance data.

Summary of findings

At the last inspection in February 2014, we rated maternity and gynaecology services as requiring improvement for being responsive and well led, particularly about patient's access and flow, governance and risk management arrangements and the vision and strategy for the service. During this inspection, we found that although good progress had been made in the implementation of recommendations following the Morecambe Bay investigation, maternity services at Royal Lancaster Infirmary required improvement for being safe and well-led.

Processes were in place for infection prevention and control, however, hand hygiene compliance particularly amongst medical staff was low. Audits showed that the 'five steps to safer surgery' procedures (World Health Organization safety checklist) were not completed consistently, and this level of practice was inadequate. Staff were aware of the procedures for safeguarding vulnerable adults and children, however the infant abduction policy had not been tested for some time. Although, the service was caring, the behaviours and attitudes of certain staff were said to be obstructive and created barriers to communication and change. Midwifery supervision investigations were carried out separately to the trust's investigation process; it was therefore not clear how midwifery supervision investigations and the trust investigations would align.

Governance structures and processes were evolving. There were mixed comments about the effectiveness of

Maternity and gynaecology

leadership. The managerial lines of responsibility and accountability were not clear at ward manager and matron level, which led to confusion and lack of ownership. There was good progress with the completion of actions against the Kirkup recommendations; this work was on-going and areas were yet to be implemented and fully established across the trust.

Medical and midwifery staffing levels were in line with national recommendations for the number of births on the unit each year, although there was high use of midwifery agency staff to cover vacancies, maternity leave and sickness absence. There was no dedicated anaesthetic cover for obstetrics, out of hours cover was provided by a resident trainee anaesthetist who provided cover for maternity and intensive care; this was supported by a non-resident consultant anaesthetist. The service felt this was sufficient for the intensity of the work, although it was accepted that this fell short of national guidelines. The service participated in local and national audits and external peer reviews to improve patient care. Trust outcomes of care for women were meeting expectations in most areas and where areas required improvement, action had been taken. Women were treated with dignity and respect.

Are maternity and gynaecology services safe?

Requires improvement

Medical and midwifery staffing levels were in line with national recommendations. However, there was high use of midwifery agency staff to cover vacancies, maternity and sickness absence. There was no dedicated anaesthetic cover for obstetrics, out of hours cover was provided by a resident trainee anaesthetist for maternity and intensive care; this was supported by a non-resident consultant anaesthetist. The divisional clinical director felt this was sufficient for the intensity of the work, but it was accepted that this fell short of national guidelines. However, there was no evidence to suggest there were any serious incidents or complaints relating to delays in obtaining an anaesthetist.

There were processes in place to ensure infection prevention and control was managed effectively, however, there was low compliance for hand hygiene assessments particularly amongst medical staff. Staff were aware of the procedures for safeguarding vulnerable adults and children, however, the infant abduction policy had not been tested for some time. The World Health Organisation (WHO) 'five steps to safer surgery checklist' was not consistently completed and this level of practice was inadequate.

Incident reporting had improved since the last inspection. The trust had mechanisms in place to identify safety concerns and address themes. Information was collected and reviewed about standards of safety and shared with staff through safety briefings.

Incidents

- Incident reporting had improved since the last inspection. Staff were aware of what incidents to report and said they received feedback.
- If a serious incident was raised, then the head of midwifery, divisional director, chief nurse and medical director were informed. When a serious incident was identified, the division undertook a root cause analysis investigation using a universal template.

- Rapid reviews were requested on all moderate and above incidents, including: near misses**.** These were discussed and reviewed at the Patient Safety Summit on a weekly basis.
- There were six serious incidents reported for maternity across the trust, including: a maternal death, intrapartum fetal death and intrauterine death between May 2014 and April 2015. We reviewed a sample of root cause analysis investigations which identified the care and service delivery problems, contributory factors and root causes. The action plans showed changes had been made to guidelines; audit of documentation had been undertaken; and further training and supervision had been given to staff.
- An audit of compliance with Duty of Candour was put in place following the change in legislation from October 2015, and had been repeated for the period April to June 2015. The audit for women's and children's services showed that where something had gone wrong women had been informed of the incident and had received an apology.
- Joint perinatal mortality and morbidity meetings were held quarterly across the three hospital sites. A multi-disciplinary peer group reviewed all serious cases, including stillbirths and neonatal deaths. Attendance included clinical staff from the Women's and Children's division. Minutes for December 2014 to June 2015 showed that recommendations to improve practice had included changes to documentation and clinical practice and review of guidelines.

Safety thermometer

- Maternity services had started to use the national maternity safety thermometer. This allowed the maternity team to review harm, and record the proportion of mothers who had experienced harm free care. The maternity safety thermometer measures: harm from perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. In addition, it identified those babies with an Apgar (a method to quickly summarize the health of the new-born) of less than seven at five minutes and those babies who were admitted to a neonatal unit.
- A snapshot of the maternity safety thermometer March 2015 to June 2015, showed 83% of women experienced harm free care.

Cleanliness, infection control and hygiene

- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) in 2014/15.
- Areas we visited had antibacterial gel dispensers at the entrances. Appropriate signs were on display regarding hand washing for staff and visitors.
- Observations during the inspection confirmed that all staff wore appropriate personal protective equipment when required, and they adhered to 'bare below the elbow' guidance, in line with national good hygiene practice.
- The CQC Survey of Women's Experience of Maternity Services (2013) showed that the service scored 'about the same' as other trusts for cleanliness, infection control and hygiene.
- Environmental cleanliness audits for March 2015 showed 98% compliance for the delivery suite.
- Women were screened for MRSA before undergoing elective caesarean sections.
- Data for April 2015 for hand hygiene assessments showed 63% of midwives on the delivery suite and maternity ward and 86% on gynaecology outpatients were compliant with hand hygiene requirements. Medical staff compliance was low at 25%. Action included practice educators and education midwives to support managers in targeting staff who urgently needed to undertake an assessment.
- Systems were in place to identify women for Hepatitis B and HIV at booking to ensure that relevant patients were managed on the correct care pathways. Data between January and March 2015 showed 100% of women had been screened for HIV and Hepatitis B.

Environment and equipment

- There was adequate equipment on the wards to ensure safe care, specifically, cardiotocography (CTG) and resuscitation equipment. Staff confirmed that they had sufficient equipment to meet patients' needs.
- There were new infant resuscitation cabinets in all delivery rooms, however these could be connected to the oxygen inlets in the room and therefore portable cylinders were required. We were informed that this equipment was not in use at the time of our inspection, as staff needed to be trained. In the interim, there were five resuscitaires available.

- Maintenance of equipment was regularly checked by the trust's medical engineering department and records showed that staff carried out equipment checks each day. However, there was confusion among staff as to what the labels meant, for example, if the label said "May 2015", staff did not know if this was the date it was tested or when the equipment was due to be tested. When we queried this, staff contacted the maintenance department and confirmed the labels identified the date the equipment was last tested.
- Signs in the antenatal clinic were not sufficiently clear. We observed some women were waiting in the wrong areas for treatment.
- Delivery rooms did not have piped ENTONOX (nitrous oxide and oxygen); staff used portable bottles. We were informed that this was normal practice on the unit and replacements were easy to obtain.
- There was no electronic baby tagging system, although there was security control at the entrance to the labour ward. Although the reception was not in close proximity to the entrance, the TV and door release were situated together at reception and monitored from there. The door release for the unit was with the TV that showed who was at the door.
- A new neonatal resuscitation trolley had been put on the delivery suite. There was some confusion about who had responsibility for this. The delivery suite staff felt that this was the responsibility of staff from the neonatal unit and the neonatal unit staff felt that they had given responsibility to the delivery suite. At the time of the inspection, this was not being checked or used due to these discrepancies.

Medicines

- There was good pharmacy support on the wards. Pharmacists attended regularly to help with take home drugs, which avoided delays in discharge and women going home without their medication.
- Medicines were stored in locked cupboards and trolleys in all of the units.
- Medicines that required storage at a low temperature were stored in a specific medicines fridge. All of the maximum and minimum fridge temperatures were checked and recorded daily; there were no gaps in recording.
- Records showed the administration of controlled drugs were subject to a second, independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded.

Records

- We reviewed seven records which were completed to a good standard. Each record contained a pathway of care that described what women should expect at each stage of their labour. Risk assessments such as venous thromboembolism were completed appropriately.
- Staff told us they completed paper and electronic records which was time consuming; sometimes taking over an hour to complete records after a delivery.
- Women carried their own records throughout their pregnancy and postnatal period of care. The personal child health record (also known as the PCHR or 'red' book) was given to parents before discharge.
- Standard operating procedures and care pathways were included in the records for care of women with diabetes, hypertension or a high body mass index (BMI) in pregnancy.
- Audit showed areas for improvement included completion of fluid balance charts and the maternity early warning score documentation.
- Trust data showed 96% of staff had completed information governance training.

Safeguarding

- Staff demonstrated a good understanding of the need to ensure vulnerable people were safeguarded, and understood their roles and responsibilities for identifying and reporting any concerns.
- There was a dedicated safeguarding midwife and safeguarding champions on the wards.
- Data for safeguarding training showed 99% of staff had completed vulnerable adults training. Children's safeguarding training showed 99% had completed level 1, 82% level 2 against a trust year-end target of 95%. Safeguarding level 3 training was in date for staff and over a three year period was 94.9% in July 2015 based on staff who had trained in 2013 and would be in date until 2016. The trust was working with the IT team on the data set to ensure yearly monitoring to an accumulated compliance over a three year period.
- The trust had a child and infant abduction policy; however, staff were unable to recall when the last time a

practical test of the procedures had been carried out. This was not in line with trust policy which stated that 'there is a need to do a physical test on a 12 month basis to ensure that the procedures work correctly and that staff understand how they work'. Staff said women were informed to keep their baby with them at all times and were aware of the lock down procedures. In complex cases where women were unable to care for their baby, one-to-one staffing would be provided.

- Staff told us not many women were admitted with female genital mutilation (FGM); however staff had attended a new study day which included FGM and radicalisation.
- Children aged 13 to16 were asked about their sexual activity and referred to the appropriate agencies where required. Girls under 13 years of age were automatically referred to the safeguarding team.

Mandatory training

- Staffing rosters were arranged to allow staff time to attend mandatory training. The training covered a number of topics which included obstetric emergency skills training, adult and neonatal resuscitation. Staff had individual training needs analysis records in place.
- The service had introduced PROMPT (Practical Obstetric Multi-Professional Training) an evidence based multi-professional training package for obstetric emergencies.
- There was a dedicated practice development midwife who monitored attendance and organised training sessions. Training records showed that staff had completed training in areas such as infection control (level 1 99% and 96% level 2), fire safety (78%) and resuscitation (89%) against a year end trust target of 95%.

Assessing and responding to patient risk

- Midwifery staff used an early warning assessment tool known as the Maternity Early Obstetric Warning System (MEOWS) to assess the health and wellbeing of women who were identified as being at risk. This assessment tool enabled staff to identify and respond with additional medical support if required.
- A trust audit of the WHO surgical safety checklist of a sample of ten records in June 2015 for Royal Lancaster Infirmary showed 30% of the WHO surgical checklist was appropriately commenced, 20% was appropriately completed, 40% had not been completed appropriately and 40% was not applicable. This had been escalated to clinical leaders in theatres. This level of practice was inadequate.
- The service was using a sepsis screening tool to monitor observations for patients with infection.
- The unit used 'fresh eyes', a system which required two members of staff to review fetal heart tracings. This meant the interpretation and accuracy of the tracing was enhanced.
- There were escalation plans and handover to transfer processes for women requiring high dependency care.
- Women who were identified as low risk followed the low-risk antenatal care pathway; if risk factors were identified, a referral was made to the appropriate professional for example, consultant, teenage pregnancy midwife or mental health midwife.

Midwifery staffing

- The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists (RCOG) guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of 1 midwife to 25 births compared to the RCOG recommendations of 1 midwife to 28 births.
- A total of 21 midwives had been appointed across the trust, with two starting in June 2015, a further two were awaiting a start date to be confirmed and the remaining 17 were undergoing pre-employment checks. The residual midwifery vacancy rate was 6.1%.
- The planned and actual staffing levels were displayed on noticeboards on each ward. On the days we inspected the wards, there were no shortfalls in planned staffing levels. Extra staff were on duty for elective caesarean sections.
- A staffing escalation policy was in place to address any shortfalls. The service had assessed staffing numbers and skill mix using the workforce planning tool Birthrate Plus and was using a red flag system to identify when there were too few midwives on hand which may impact on care. The matron said the service was considering using the National Institute of Clinical Excellence (NICE) Guideline on Safe Midwifery Staffing for Maternity Settings released in February 2015.
- A handover of care occurred three times a day. This was audited and all senior staff signed a pro-forma to say they had handed over or received handover.

- The labour ward co-coordinator was technically supernumerary but this was not always possible due to the intensity of workloads on the labour ward.
- There were high levels of agency use. Trust data showed that between January and May 2015, 15.4% agency staff were covering vacancies, maternity and sickness absence.
- There were 4.8 vacancies within community midwifery of which 4.0 WTE had been recruited and would commence in post in August 2015. Community midwifery caseload numbers was 1 midwife to 87 women. The service was looking at ensuring caseload to midwife ratios was fairly distributed, with the additional investment and recruitment to community midwife posts.

Medical staffing

- There were ten consultants at the Royal Lancaster Infirmary who provided 84 hours cover per week on the labour ward. This was in line with the recommended RCOG safer staffing standards for a service delivering fewer than 2,500 births per year. Two new consultants had recently been appointed and would be commencing employment in August 2015.
- Consultant-level and junior-level staffing was similar or better than the England average with the exception of registrars (STR 1-6), which was below the England average (37% compared to 50%). However, the increased consultant cover compensated for this.
- Two consultants covered nights without a middle grade on call so the hours of consultant presence was higher.
- There was no dedicated resident on-call anaesthetist for maternity. Between 8am and 6pm, anaesthetic consultants (20 hours per week) or senior trainees covered the labour ward. Between 6pm and 8.30am, a resident trainee anaesthetist covered maternity and intensive care; a non-resident consultant anaesthetist supported this. For elective cover there were four consultant labour ward sessions (5 hours) and senior anaesthetic trainees provided the remaining labour ward sessions. There were also 2.5 elective caesarean section lists per week and one antenatal clinic on alternate weeks. The divisional clinical director felt this was sufficient for the intensity of the work, although it was accepted that this fell short of national guidelines. However, there was no evidence to suggest there were any serious incidents or complaints relating to delays in obtaining an anaesthetist. Staff providing anaesthetic cover were either resident in the hospital or living in hospital accommodation.
- Locum usage between January and May 2015 was 9%. Long-term locums were commonly used to ensure consistency.

Major incident awareness and training

- A business continuity plan for safe staffing was in place. This included the risks specific to each clinical area and the actions and resources required to support recovery.
- There were escalation processes to activate plans during a major incident or internal critical incident.
- Multi-disciplinary team training days were in place which allowed the use of in-house and multi-professional obstetric emergency skills and drills using the trust's own policies and guidelines.

Are maternity and gynaecology services effective?

Good

Women received care in line with current evidence-based guidance and standards. The service participated in local and national audits and external peer reviews to improve patient care. Information about women's care and treatment, and their outcomes, was routinely collected and monitored. Care outcomes for women met expectations in most areas; where improvements were required the service had taken action.

The learning needs of staff were identified and training was put in place. Action had been taken to improve medical education for junior doctors. Multi-disciplinary teams worked collaboratively. Consent practices were monitored and reviewed, and women were involved in making decisions about their care and treatment. There was some awareness by staff of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, although this could be improved.

Evidence-based care and treatment

- Women using maternity and gynaecology services were receiving care in line with the National Institute of Clinical Excellence quality standards. The maternity

guidelines group reviewed guidelines, and staff were consulted on amended guidelines and procedures to reflect changes in practice. Guidelines were audited regularly after being introduced and action plans were implemented and monitored where required.
- There was a clinical audit programme 2015/16 which detailed plans for national audits, divisional priorities and educational audits. The plan included the audit supervisor, completion date and frequency.
- The maternity service had an audit midwife who worked closely with two clinical audit leads across the trust's hospital sites. Audits were discussed each month and included areas such as: emergency and elective caesarean section rates, third and fourth degree tears, pre-eclampsia and postpartum haemorrhage.
- An audit in July 2015 of venous thrombo-embolism (VTE) risk assessments showed actions identified included additional training to promote correct VTE assessment and to ask newly employed doctors or midwives to complete VTE audit to facilitate learning on how to correctly complete VTE forms.
- Minutes of the audit meeting June 2015 showed positive audit results for outpatient hysteroscopy with recommendations for up-dating of leaflets to include importance of pre-operative analgesia.

Pain relief

- Women were provided with information to make them aware of the pain relief options available to them.
- We were told there was a designated obstetric anaesthetist during the day Monday to Friday; however, this was not always the case during the night and at the weekend. Staff said this could sometimes cause delays in women obtaining epidurals in a timely manner.
- Clinical records showed that pain assessment charts were completed at least four-hourly or following any pain-related intervention.

Nutrition and hydration

- Breastfeeding initiation rates for deliveries that took place in the hospital between February 2015 to June 2015 varied between 62% and 71%, which was better than the trust target of 60%.
- At the time of inspection, the trust had not registered intent to undertake the United Nations Children's fund (UNICEF) Baby Friendly Initiative (BFI) Accreditation Scheme. The aim of this scheme was to train staff in supporting women to make an evidence based choice in how to feed their baby.

Patient outcomes

- There were no risks identified in maternal readmissions, emergency caesarean section rates, elective caesarean sections, neonatal readmissions or puerperal sepsis and other puerperal infections (Hospital Episode Statistics January 2014 to December 2014).
- The normal vaginal delivery rate was slightly lower (worse) than the national average (57.8% compared to England average of 60.1%).
- Elective caesarean section rates were slightly higher (12.9%) than the national average of 10.9%.
- Emergency caesarean delivery was 13.6%, which was better than the England average of 15.1%.
- The maternity performance dashboard for the Royal Lancaster Infirmary showed that between February and June 2015, there were eight reported third and fourth degree tears, which equated to just less than 1% of births. There was a rolling audit programme for tears which would be next presented in August 2015. Perineal suturing updates and starter workshops were regularly held for staff.
- There were no cases of maternal sepsis reported between February and June 2015.
- Forcep delivery rates were slightly higher (worse) than the England average, whilst ventouse deliveries (use of a suction cup) were slightly lower (better) than the England average.
- There were four stillbirths reported between February and June 2015. This was within the trust ceiling of harm of five.
- Post-partum haemorrhage (PPH) rates were above the trust target. Between April and June 2015, there were 16 PPHs against the trust's alert of two cases per month. An audit had been undertaken which identified areas for action such as: changes to guidelines; simplified pro-forma on the PPH trolley as a prompt for correct management and documentation; improved management of PPH through skills and drills training; and clarification of guidance on the transfusion of blood products. Action plans showed clear timeframes for completion and identified the person responsible for implementing the actions.

Maternity and gynaecology

- Between 1 June 2014 and 31 May 2015 there were 229 babies (all gestations) admitted to the neonatal unit at Royal Lancaster Infirmary. Of these the primary diagnosis for babies born at term were mainly due to respiratory distress (42), hypoglycaemia (18) and feeding issues (6). Six babies were transferred to other units. Trust wide data shows there was 11 unplanned admissions to neonatal intensive care units external to the trust. These transfers all seemed within normal practice and were not unusual.
- The service participated in the UK National Screening Committee: antenatal and new-born screening education audit. Trust data showed the rates of avoidable repeat tests for new-born blood spot sampling had improved from 4% in April 2015 to 0.6% in May 2015, which was in line with national targets of no more than 0.5% and 2%.
- The National Neonatal Audit Programme 2014 showed improvements had been made compared to 2013 across the five domains with three out of the five indicators achieving national targets. The two areas requiring improvement were babies with a gestational age of <32+0 weeks or <1501g at birth undergoing 1st Retinopathy of Prematurity (ROP) screening in accordance with the current national guideline recommendations and the proportion of babies <33+0 weeks gestation at birth are receiving any of their mother's milk when discharged from a neonatal unit. The trust was reviewing these areas and developing an action plan for improvement.

Competent staff

- Trust data for maternity and gynaecological services showed 97% of midwives and nursing staff, and 89% of medical staff had a received a yearly appraisal.
- Newly qualified midwives completed a two year preceptorship programme which provided a framework to develop staff from a band 5 to a band 6 in maternity care. This included rotation across all sites.
- Agency staff had started to attend study days and mandatory training. They had access to the hospital e-learning system.
- Staff said they had opportunities for professional development, for example, one midwife was undertaking training to provide active birth classes.
- We observed a doctors appraisal process. They were being supported to complete their portfolio.
- Specialty trainee doctors at level 6 said they had more training opportunities than the juniors which were sometimes limited. An external review of junior doctor training in November 2014 showed that trainees were experiencing poor access and support from seniors, feedback and educational supervision. The trust had developed an action plan, which included the appointment of two consultants with an interest in medical education. Completion of the action plan was being monitored by Health Education North West.
- A first year student midwife informed us that mentorship within the service was very good and supportive. They were able to undertake different tasks to enable learning and development. There was good reflective practice.
- The North of England Local Supervising Authority's annual report to the Nursing and Midwifery Council October 2014 showed the trust had met the domains relating to: statutory supervision of midwives and clinical governance; team working; leadership and development and supervision of midwives; and interface with users'. One domain was partially met, regarding the profile and effectiveness of statutory supervision of midwives. This was associated with timely inputting of information onto the LSA database and attendance at LSA events, both of which were underpinned by a lack of time. This would improve with the appointment of a full time dedicated supervisor of midwives (SoM).
- The range of caseloads held by the SoM fluctuated from 12 to15 midwives, which was in line with the recommended ratio of 15 midwives for each supervisor**.** All midwives had 24-hour access to supervisors. Some annual supervisory reviews were out of date because of workloads impacting on supervisory time, however, a full time dedicated SoM had been appointed and an action plan was in place to ensure compliance.
- Skills passports had been developed and sent to all registered healthcare professionals. These documents provided an outline of clinical skills development of all staff beyond the mandatory requirement and sat outside the training needs analysis.

Multidisciplinary working

- A safety huddle took place every morning which was multi-disciplinary and included the anaesthetist, obstetricians and midwives. The huddle discussed any incidents, staffing and activity from the night before.
- Transitional care was currently an informal arrangement. Midwives observed babies and carried out two hourly observations which proved to be a challenge when the ward was busy. Plans were in place to formalise transitional care as part of the integrated maternity pathway. Staff said there was good multidisciplinary team (MDT) working with paediatrics and it was easy to obtain support out of hours from the neo-natal unit or outreach service.
- There was close MDT working with the midwifery led unit at Westmorland General Hospital. The labour ward at the Royal Lancaster Infirmary provided on call support after 8pm for any internal diverts.

Seven-day services

- Out-of-hours services were available in emergencies. All women could report to the hospital in an emergency either via A&E or maternity reception.
- There was seven day medical cover provided with the minimum of a resident middle grade doctor, and at times a resident consultant.
- There was no dedicated team specifically for obstetric theatres overnight; cover was provided by a theatre team who responded to emergencies in the first instance, including obstetric emergencies. In support of the on-duty night team there was an on-call team available who would be called to manage a second and subsequent emergency, this team was only used if the second or subsequent emergency was an obstetric emergency; all members of this second team had to respond within 30 minutes of the call or be resident whilst on-call.
- The day assessment unit DAU was open Monday to Friday 7.45am to 8.30pm. Women could attend DAU for various reasons, for example, requiring CTG monitoring or having an episode of reduced fetal movements. Out of hours, women could access the labour ward.

Access to information

- During transfer of women between trust sites or to other hospitals, there were processes in place to ensure all appropriate documentation and case notes travelled with the woman, along with the results of appropriate investigations that had been carried out.
- There were effective processes in place to ensure that the results of the antenatal screening tests were followed up and actioned in a timely way and in line with protocols. The screening co-ordinator worked closely with the laboratory to ensure investigations were actioned. Results were checked and high risk women given an appointment to be seen in clinic. Each trust site also had a main screening contact co-ordinator to ensure systems were in place when staff were on leave.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women confirmed that medical staff spent time talking through the risks and benefits when deciding on birth options. Women were provided with sufficient information to make an informed decision. Consent forms were completed in line with Department of Health consent to treatment guidelines.
- A divisional wide audit of records showed 100% notes had clear documentation of discussion regarding risks and benefits for any interventions.
- Staff were aware of Fraser guidelines for girls below the age of 16 to consent to their own medical treatment, without the need for parental permission or knowledge.
- Staff had some awareness of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, however when asked to talk through the processes we found staff had limited knowledge in these areas. Training was included as part of the safeguarding workshops.

Are maternity and gynaecology services caring?

Good

Maternity and gynaecology services were caring. The NHS Friends and Family Test for May 2015 showed the majority of women would recommend the maternity service. Women spoke positively about their treatment by clinical staff and the standard of care they had received. However, there were occasions when women had to wait for support due to workloads on the post-natal ward.

Staff interacted with women in a respectful way. Most women were involved in their birth plans. There were processes in place to ensure women received emotional support where required.

Maternity and gynaecology

Compassionate care

- Feedback from the NHS Friends and Family Test for May 2015 showed 100% of women would recommend antenatal care, birth and postnatal care. For the same period, scores for women who would recommend antenatal community provision were 90% and 100% would recommend postnatal community care.
- The trust scored about the same as other similar size trusts in all 17 indicators in the CQC Survey of Women's Experience of Maternity Care (2013).
- The NHS Friends and Family Test for June 2015 showed that 98% of women would recommend gynaecology services to their family and friends.
- Most women said they had received excellent antenatal and postnatal care. Some women said midwives were too busy on the post-natal ward which had resulted in them waiting for assistance, for example, when needing support with breast feeding. Women had a named midwife.
- The trust was in line with the England average for the time taken to respond to call bells.
- The patient led assessments of the care environment (known as PLACE) for 2014 showed that the trust was slightly better than the England average for privacy, dignity and wellbeing.

Understanding and involvement of patients and those close to them

- The majority of women we spoke with said they had felt involved in their care; they understood the choices open to them and were given options of where to have their baby. However, one woman said she was given no choices or explanation as to induction of labour. Another woman said that you had to be proactive if you wanted something outside the norm, for example a home birth.
- Women were encouraged to visit the maternity unit for a tour before deciding where they wanted to give birth and to familiarise themselves with the facilities.

Emotional support

- Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death; this was facilitated by two midwives with a special interest in the care of the bereaved. Information detailing various agencies that provided counselling support for women and their families was available. An annual memorial service was also held.
- Following a loss of pregnancy, support was provided to women. Memory boxes were available with items that could be kept, to serve as memory of the baby.
- The service had a 'Listen to Mother' birth afterthoughts service which provided women with an opportunity to have unresolved issues about their pregnancy or birth experience answered.

Are maternity and gynaecology services responsive?

Good

The service was working in partnership with other organisations to implement an integrated maternity pathway. This included a more formalised neonatal transitional care pathway and midwifery led care.

Access and flow, such as clinic waiting times were managed appropriately. Women were kept informed of any disruption to their care or treatment. There was access to investigation, assessment, treatment and care at all stages of the maternity pathway. Where women had additional healthcare-related needs, there was access to specialist support and expertise.

There were processes in place for women to make a complaint or comment. Improvements were made to the quality of care as a result of complaints and concerns.

Service planning and delivery to meet the needs of local people

- The service was working with its commissioners to develop a programme for a fully integrated maternity pathway, inclusive of public health and primary medical services, which set out what women had a right to expect. This included a more formalised transitional care pathway and midwifery led care.
- The service was working closely with commissioners and other stakeholders to ensure the recommendations from the Kirkup report were implemented across all trust sites.
- There was a maternity public health strategy written in partnership with the trust's commissioners for the

geographical areas of Morecambe Bay which was refreshed for 2014/15. This was being considered through the commissioning group in how it could be delivered and linked into the work that was happening around Better Care Together; the integrated maternity care pathway and the RCOG review.
- There was a dedicated bereavement room on the labour ward situated in a quiet area. The service was raising funds to refurbish the area which would include access to the garden area.
- There were no facilities for fathers to stay overnight on the delivery or post-natal wards.

Meeting people's individual needs

- There were effective and confidential processes for women attending the nurse led pregnancy advisory service. Standard operating procedures were in place for the sensitive disposal of fetal and placental tissue. There was evidence to show women were made aware of the options for disposal and given the opportunity to discuss them.
- Women using the maternity services could access specialist midwives for the following aspects of care: diabetes; substance misuse; mental health; domestic violence. Referral pathways were in place for women with cardiac problems to be referred to a tertiary centre for treatment.
- Adjustments had been made for disabled patients. Side rooms had disabled facilities and there was access to specialist equipment where required.
- There was no specialist midwives in place to support women with high body mass index (BMI), although women who required support for weight loss with a BMI >30were referred to dieticians.
- Two midwives practiced hypnobirthing which provided women with a birth education programme, for self-hypnosis, relaxation and breathing techniques for a better birth.
- There was access to various types of pain relief for birthing women which included drug-free methods. Data showed there was a 3.2% water birth rate.
- There were 19 trained new-born hearing screening support workers. The majority of the hearing screening was completed before discharge which had improved referral rates to audiology.
- Women were routinely asked about current and previous mental illness at their antenatal booking. A maternal mental health risk assessment form was completed and women were offered review with the specialist mental health midwife to develop a plan for the perinatal period. There was on-going assessment of the woman's mental health during the antenatal and postnatal period. Referral could also be made to the crisis team and adult mental health team.
- There were a range of information leaflets in clinical areas, including: tests and screening, breastfeeding, family planning and other sources of support. The leaflets were available in different languages if required.
- Maternity services were working to an action plan developed by partners in public health to reduce the levels of maternal smoking. Women were offered Carbon Monoxide (CO) monitoring at booking and referred to smoking cessation services within GP surgeries and pharmacies. However, the performance dashboard showed the rates of CO2 screening offered, and the percentage of referrals offered for smoking cessation was below the trust target of 75% (April to June 2015 between 30% and 28%).

Access and flow

- Bed occupancy rates were lower than the England average of 57% in 2013/2014 aside from quarter 4 (January 2014 to March 2014) where occupancy levels were approximately 5% (62%) higher than the average.
- The maternity unit at the Royal Lancaster Infirmary was partially suspended once in March 2014 due to insufficient medical cover.
- The percentage of pregnant women accessing antenatal care who were booked for delivery by 12 weeks and six days between March to May 2015 was 95% which was better than the trust target of 90%.
- Most routine antenatal care was provided by community midwives. They completed risk assessments with women and gave advice and support around choice of place of delivery and birth plans. Women also attended the hospital for antenatal care. Those with high risk pregnancies attended consultant-led clinics.
- The average time for referral by a GP to treatment in gynaecology was eight weeks which was comparable to other trusts in the area.
- There was a high percentage of consultant led care. Midwives felt that the increase in consultant bookings was due to the pathway for women with a BMI over 30.

These women were initially booked under a consultant but if tests were normal, they were transferred back to midwifery led care, however, this was not always reflected on the IT system.

- There were two midwife sonographers who had completed training and competency assessments in obstetric scanning, a consultant also provided scanning sessions. The ultrasound department performed 12 and 20 week scans and other scans as required.
- Improvements had been made to waiting times for women attending the diabetic clinic. Women came in before their appointment time and received education and information about the management of diabetes and were referred to clinic straight after. Additional clinic slots were also being looked at.
- The maternity ward was a mixture of both antenatal and postnatal women and babies. It had 24 beds including eight side rooms. Room 10 was mostly used for caesarean section patients so women could be better observed by midwifery staff, and room three was an antenatal bay. Women whose labour was going to be induced and those having an elective caesarean section were also initially admitted to the ward.
- The new-born infant physical examination (NIPE) was mostly paediatric led. There were three midwives who were NIPE trained. More midwives were being encouraged to complete training to ensure that the 72 hour target for NIPE was achieved. There were some delays on the neonatal unit for NIPE in achieving the 72 hours as this was not being seen as a priority. We were told that there were five babies on the system at the time of our inspection that had breached the 72 hour target.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy. Information was given to women about how to make a comment, compliment or complaint. Matrons gave women contact cards so they could call if they had any worries or concerns during their stay.
- There were 21 complaints for maternity and gynaecology services at the Royal Lancaster Infirmary between July 2014 and May 2015. The main themes related to care and treatment, staff attitude and communication.
- Learning from complaints and concerns was discussed at monthly and weekly governance and risk management meetings.

Are maternity and gynaecology services well-led?

Requires improvement

The managerial lines of responsibility and accountability were not clear at matron and ward manager level which led to confusion and lack of ownership. Staff satisfaction was mixed, with some staff feeling isolated and unsupported. Although, the service was caring, the behaviours and attitudes of certain staff were said to be obstructive and promoted barriers to communication and change. Some staff were aware of the vision and strategy for the service but this was variable.

Midwifery supervision investigations were carried out separately to the trust's investigation process; it was therefore not clear how midwifery supervision investigation and the trust investigation would align to meet best practice guidance. Governance structures were evolving. There were processes in place to ensure risks were reported and monitored, and action taken to improve performance however further work was required to the maternity performance dashboard to effectively capture and monitor all risks. There had been good progress made against the completion of actions against the Kirkup recommendations; this was work in progress and a number of areas were yet to be implemented and fully embedded across the trust including the strengthening of collaborative working across the hospital sites.

There were examples of public engagement and some improvement had been made in staff engagement.

Vision and strategy for this service

- The strategy for maternity services was aligned with the trust's operational development strategy 'Better Care Together'. The five year plan included a fully integrated maternity care pathway to meet the needs of women focussing on the provision of a midwife led service for birth and transitional care services for neonates. There were clear timescales for agreed actions, and work streams had been assigned to project leads responsible for implementation.

- Some staff were aware of the vision and strategy for the service however this was variable. There was a service change plan which set out timescales for communication and engagement of staff during 2015/16 and 2016/17.

Governance, risk management and quality measurement

- There was a Morecambe Bay Investigation Sub-Committee which monitored and provided scrutiny of the recommendations and developments, in relation to the governance, assurance and management arrangements being undertaken in response to the Kirkup report published on 3 March 2015. The sub-committee was chaired by a non-executive director with membership from service user representatives, a public governor and an external expert. The sub-committee reported monthly to the Board of Directors. The Sub-committee had met on17 April and 11 May 2015. Minutes showed that good progress had been made since the trust received the report. The trust had met its deadlines in the report for achieving the recommendations to date. All of the projects are on track.
- A Kirkup Report Implementation Group ("the KRIG") had the day to day responsibility to implement and deliver the agreed action plan, and provided reports on progress to the sub-committee. The process for midwifery supervisory investigations was not clear. Investigations were carried out separately to the trust's investigation process and it was not clear how the supervision investigation and the trust investigation would align. The HOM said that the full supervisory report would not be shared with the trust but a summary report was sent to the Executive Chief Nurse as well as the HOM that provided a summary of findings, actions taken by supervision and or the midwife and any further actions required of the midwife. The full report was deemed confidential under section 4, rule 9 of the midwives rules and standards 2012 unless requested under the data protection act.. Where there had been a trust RCA investigation and a supervisory investigation as a result of deficiencies in a midwives clinical practice, reports have been shared with parents where possible at the same time. Parents may still receive two separate reports with different timelines and recommendations as the reports and investigations looked at different things. Factual information that supported these investigations was shared and discussed across supervision and risk management, governance teams.
- Governance structures and processes were evolving. Divisional governance meetings were held each month across the hospital sites. Minutes of 'we-see' (workforce, efficiency, safety, effectiveness and experience) governance forums showed areas discussed and actions taken.
- To support the governance process, there was a full time risk midwife, governance lead and quality and safety midwife who were the interface between management and all other staff in maternity and gynaecology in dissemination of risk management.
- The risk register was reviewed and updated through the governance processes. There was some alignment of what staff had on their worry list with what was on the risk register such as staffing levels.
- The service had developed a maternity dashboard. The dashboard is a clinical performance and governance scorecard and helps to identify patient safety issues in advance. We observed that a number of areas such as workforce, some clinical outcome indicators and risk incidents and complaints were not included in the dashboard as recommended by the RCOG good practice guidelines (No 7. January 2008). We discussed assurance processes and monitoring against the dashboard with the senior team who acknowledged that further analysis and action planning was required to ensure all risks were captured and that the dashboard was being revised.
- The maternity risk management strategy set out guidance for reporting and managing risk. It detailed the roles and responsibilities of staff at all levels to prevent or minimise risks and their consequences.
- There was a divisional governance lead and risk manager who triaged all incidents. Low and no harm incidents were managed locally on the wards. Rapid Reviews took place for incidents with an actual impact of moderate risk.
- SoMs were involved in practice issues. The risk team sent a letter to the SoM informing them of any issues, and this linked into the practice development midwife, for example, if further mandatory training was required following an incident.

Maternity and gynaecology

- The majority of maternity and gynaecology policies and procedures were accessible to staff online and were in date and ratified. However, hard copies of guidelines on the labour ward were out of date.

Leadership of service

- The leadership structure in maternity and gynaecology was a Clinical Director, Deputy Director of Nursing and Head of Midwifery (HOM) and Divisional General Manager.
- The HOM had responsibility for maternity and gynaecology across the trust's three hospital sites. As deputy director of nursing, the HOM reported to the Executive Chief Nurse. There were three maternity matrons and a gynaecology matron who were accountable to the HOM. A deputy HOM had been recently appointed and would commence in post shortly.
- We received mixed comments from staff about the effectiveness of the leadership. Some staff said there was good team working at an operational level, however this was not effectively supported by the management structures and the HOM was not very visible on site. However, other staff said the HOM was visible, progressive and open to new ideas.
- The managerial lines of responsibility and accountability were not clear at matron and ward manager level which led to confusion and lack of ownership, particularly in terms of managing sickness absence and other workforce issues.
- The understanding of the leadership training programme amongst staff was variable; not all mangers were aware of this or had been requested to attend as part of their appraisal and professional development.
- Maternity and gynaecology unit meetings were held. Minutes showed areas discussed included: staffing, training, sickness absence, complaints and incidents.

Culture within the service

- Some staff said they were well supported and could raise concerns which would be listened to. However, other staff said they felt isolated and unsupported and didn't feel part of the team, sometimes feeling undermined by staff. They said there was a lack of direction, and roles and responsibilities were not clearly defined.
- Some staff said the behaviours and attitudes of certain staff were obstructive and promoted barriers to communication and change so the service could not effectively move forward.
- Progress was being made to ensure staff worked as one trust**.** Staff confirmed rotation across the trust's sites was work in progress. Newly qualified staff, rotated across the three sites as part of their preceptorship programme.
- The senior team told us that work was progressing on rotation to other units and tertiary centres and included looking at a 'hub and spoke' model for practice learning opportunities, in order to ensure staff had access to a wide and varied breadth of experience.
- Staff turnover between June 2014 and May 2015 was 9.87% for medical staff and 18.76% for nursing and midwifery staff against a North West average of 12.9%. The cumulative sickness absence rate for maternity and gynaecology between July 2014 and June 2015 at Royal Lancaster was 5.69% against the NHS North West target of 4.3%.

Public and staff engagement

- The service took account of the views of women through the Maternity Services Liaison Committee, which was known as Maternity Matters. The minutes from March and May 2015 showed areas such as: user experience and feedback, compliments and complaints, quality assessments and breastfeeding support were discussed.
- We spoke with a service user who was a representative on the Birth Support Group. They said the trust was trying to engage, take ideas on board and inform the public. They found the trust to be open and honest**.**
- The service used a 'you said we did' board. Changes from patient feedback included, provision of meals and drinks being served in the antenatal and postnatal day room, which enabled women to socialise and discuss postnatal care with staff and other women on the ward.
- Examples were given where service users were participating members of panels in interviews for the recruitment of new staff, including midwives.
- The findings for trust-wide staff engagement in the NHS Staff Survey 2014 demonstrated an improvement from 2013, rising to 3.65 from 3.58 (on a five-point scale), although this was below the national average.
- The service participated in the 15 Steps Challenge, designed by the NHS Institute; this encourages patients and staff to work together to identify improvements,

which may enhance the patient experience. The challenge team consisted of: a service user, staff members, a trust governor, the acting chair and director of governance and other members of the corporate governance team who walked the wards and took note of their first impressions. Action plans showed changes had been completed to the environment, signs were improved and information displays updated.

Innovation, improvement and sustainability

- Some staff said they were involved in making improvements in ward areas. For example, a recorded handover was piloted on the antenatal and post-natal ward which reduced multiple handovers. This provided more time for staff to care for women and reduced delays in shift finishing times.
- The trust nursing and governance team had worked in partnership to develop a bid for Sign Up to Safety. The bid was successful and focused on improving the assessment of fetal health through using antepartum cardiotocography (CTG); to support early appropriate interventions in the antenatal period and reduce complications. The bid enabled the trust to appoint band 7 midwife CTG champions at the Royal Lancaster Infirmary and Furness General Hospitals. Training programmes, training assessment tools and 11 CTG viewing and archiving instruments with computerised analysis facility would be provided.
- The Annual Local Supervisory Audit Report October 2014 showed that the team of Supervisors of Midwives demonstrated great commitment to their statutory role and ensured that supervision was making a difference to the quality of service within the organisation.
- Staff said there were insufficient computer terminals and that IT systems were slow which caused delays in completing delivery notes.
- The service used a new-born and infant physical examination smart tab which automatically sent screening results to the GP, baby notes, a community midwife and health visitor. The system had improved the timeliness of information on discharge.

Services for children and young people

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The children and young people's service at the Royal Lancaster Hospital includes a 21 bedded inpatient ward comprising six side rooms (one with two cots), two high dependency rooms and two bays of six beds each. There is an ambulatory care unit which contains a five bedded children's assessment unit and day care which is six bedded. There is a children's outpatient department and also a local neonatal unit which has ten cots. The neonatal unit is divided into three sections, including an intensive room containing three cot spaces, a high dependency room accommodating up to four cots and a special care room accommodating up to four cots depending on the requirements of the service. During the period 1st June 2014 to 31st May 2015, 11,170 children and young people were seen in the emergency department, 3108 were seen in the children's assessment unit, 554 to the day case unit and 1176 children were admitted to the children's ward.

As part of our inspection, we spoke with five parents, carers and their children. We also spoke with a range of staff at different grades including nurses, agency staff, junior doctors, a play specialist, ward managers, the clinical director, the clinical lead, the assistant chief nurse, consultant paediatricians, senior managers and support staff.

Summary of findings

Following our previous inspection in February 2014, we rated children and young people's services at this hospital as "Requires Improvement". As part of our inspection, we identified issues regarding staffing, resuscitation equipment, poor hand hygiene, incident reporting, pain assessments and the trust's response to audits.

At this inspection we found that incidents were reported appropriately; however a rapid review was completed for patient safety incidents that were identified as moderate, major or catastrophic. As a result not all significant incidents were subject to a thorough investigation where lessons learned could be identified, potentially meaning that incidents could reoccur. For those incidents that did undergo an investigation, the lessons learned had been shared with staff via newsletters and within 'safety huddles'. Medical staffing levels remained an area of concern. Within this inspection we found medical staffing was not at full establishment at the Royal Lancaster Infirmary, and the use of locum cover was still high.

There was a special care room located at the end of the neonatal unit that did not have a member of staff situated in it at all times. Due to the design and layout of this space and the way in which staff were deployed we found there was a risk that if a baby deteriorated in this area staff would not necessarily be alerted.

Services for children and young people

There was much improvement in hand hygiene with good practice being observed. At the last inspection there was only one resuscitation trolley on the children's ward which was situated in a side room. As part of this inspection we found this was still the case. However, we were told the trust had purchased two new resuscitation trolleys but only one had been implemented. The trolley was large for the side room it was situated in and would not be easy to remove if the room was occupied. On checking the trolley, we found that some items were missing. The trust's abduction policy was not being adhered to as it stated a physical test should be carried out on the policy annually but this had not happened for a number of years.

Parents and children were generally satisfied with the care they received and felt they had been kept well informed. They told us staff were compassionate and caring.

Are services for children and young people safe?

Requires improvement

At our last inspection there was only one resuscitation trolley on the children's ward which was situated in a side room. As part of this inspection we found this was still the case. The ward had purchased two new resuscitation trolleys, one of which had replaced the previous trolley but was still situated in a side room. The trolley was large for the room it was situated in and could not be easily removed if the room was occupied. On checking the trolley, we found that some items were missing.

There was a special care room located at the end of the neonatal unit that did not have a member of staff situated in it at all times. A wall that contained a large window separated the main neonatal unit and the high dependency unit. When we inspected this area we found babies in there with no staff or parent supervision. Staff told us that often this area was monitored by staff in the intensive care area, who observed the babies through the window. On inspection we found the blinds on the windows were closed. Therefore if a baby deteriorated in this area staff would not necessarily be alerted.

There were nurse staffing vacancies across children and young people's services. The most significant staffing vacancies being in the neonatal unit, which was at 9.9% and the children's ward at 8.7% at the time of the inspection. Agency and bank staff were used to fill the nursing vacancies. Similarly medical staffing was not at full establishment and there was high usage of locum staff to fill gaps in the rota. Trust data identified 99% of staff had completed safeguarding children level one training, which was higher than the trust target of 95%. However the completion rates for levels two and three were lower than the trust target. The trust's abduction policy was not being adhered to as it stated a simulation test should be carried out on the policy annually but this had not happened for a number of years.

Incidents were reported within service and staff were knowledgeable about what types of incident they needed to report. Areas we visited were visibly clean and tidy. Fridge temperatures were checked and recorded daily on the children's ward. However, temperature ranges were

noted to be out of the recommended range for a significant length of time. Staff were not familiar with the recommended range of temperatures or how to reset the fridge. All controlled drugs on the children's ward were in date and accurately recorded. On the neonatal unit we found two bottles of morphine that were past their expiry date, one of which was clearly marked as 'expired.' In the outpatient department, we found records containing patient identifiable data were not being stored securely and were accessible to members of the public.

Incidents

- Incidents were reported using an electronic reporting system. Staff were knowledgeable about what types of incident they needed to report and could demonstrate how these would be recorded and escalated.
- There had been four serious incidents within the children and young people's service requiring investigation between 1st May 2014 and 31st June 2015, including a neonatal death, a delay in transfer of a child, medication incidents and a delayed diagnosis. These incidents had been investigated by the children and young people's divisional leads and lessons learned and recommendations had been identified and implemented.
- Lessons learned from incidents were shared within newsletters emailed to staff and also at daily staff safety huddles for a one week period. These were subsequently transferred to a communications folder and all staff had to sign to identify they had read them. Staff gave examples of incidents where lessons learned had been implemented in practice. Lessons learned were also shared from the North West Neonatal Network of Lancashire and South Cumbria and examples were given of this.
- Staff within all paediatric disciplines were familiar with the term 'Duty of Candour' (the regulation introduced for all NHS bodies in November 2014, meaning they should act in an open and transparent way in relation to care and treatment provided) and families had been informed of incidents involving their child.
- Perinatal mortality and morbidity meetings were held on a quarterly basis.

Cleanliness, infection control and hygiene

- All areas inspected were visibly clean and hygienic.
- Fully completed cleaning schedules were in place with clearly defined roles and responsibilities.
- Posters were displayed on the door of each room on the children's ward to act as a reminder for staff, patients and visitors to wash their hands. Hand wash gels were in prominent positions on the entry to each bay and side room on the children's ward.
- Hand wash audits were completed weekly on the children's ward. These showed that staff were mostly compliant with trust policy. The results were displayed for staff to see.
- On the neonatal unit hand wash gel was available at each cot space and staff were observed washing their hands when entering and leaving the areas.
- Single occupancy rooms were available on the children's ward to use as isolation rooms for patients identified as an increased infection control risk. We observed barrier nursing on the neonatal unit for a baby who had developed parainfluenza. This baby was effectively barrier nursed in a side room to prevent the spread of infection. Barrier nursing is a set of stringent infection control techniques used in nursing. The aim of barrier nursing is to protect medical staff against infection by patients, particularly those with highly infectious diseases.

Environment and equipment

- The medical devices register for the children and young people's service showed that all medical devices kept within the service were calibrated appropriately. The scales were seen to have had portable appliance testing (PAT). PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.
- All equipment we checked was up to date with testing and fit for purpose.
- At our last inspection there was only one resuscitation trolley on the children's ward which was situated in a side room. Also the resuscitation trolley had things on display which could be easily removed without being noticed. Concerns were identified with difficulties in accessing this when the room was in use and it was a distance from the day surgery and assessment unit. As part of this inspection we found this still to be the case. However the ward had purchased two new resuscitation trolleys, one of which had replaced the previous trolley but was still situated in a side room. The other trolley

had not yet been put into operation. The trolley in use was large for the room it was situated in and could not be easily removed in an emergency if the room was occupied.

- On checking the resuscitation trolley we found that there was no paediatric carbon dioxide indicator and no size one tracheal mask (we were told that this had been ordered but not received). The top drawer was found to be very full and cluttered with various pieces of equipment, which would make it difficult to find specific equipment in an emergency. The drug box was due to expire at the end of the month but there was nothing in place to highlight this. Staff informed us that pharmacy had a record in place of expiry dates.
- Staff told us there were insufficient oxygen points on the neonatal unit as they could not plug in continuous positive airway pressure (CPAP) at the same time as oxygen, so therefore they had to quickly unplug one to enable them to plug the other one in. BAPM standards recommend that there should be at least three oxygen points per cot space, however there was only one oxygen point per cot space on the neonatal unit. CPAP is a treatment that uses mild air pressure to keep the airways open. Staff had recently raised this as a concern to managers; however this was not on the risk register.
- The cot areas on the neonatal unit had limited space around them. There was a special care room located at the end of the neonatal unit that did not have a member of staff situated in it at all times. BAPM standards identify that the staffing ratio for babies in a high dependency unit should be one registered nurse for every two babies. A wall that contained a large window separated the intensive care area of the neonatal unit and the high dependency unit. There was no direct communication between the two units. When we inspected the high dependency area we found babies in there with no staff or parent supervision. Staff told us that often this area was monitored by staff in the intensive care area, who observed the babies through the window. On inspection we found the blinds on the windows were closed. Therefore if a baby deteriorated in this area staff would not necessarily be alerted. Therefore deployment of staff on the neonatal unit was inadequate. Staff that we spoke to did not see this as a concern.

Medicines

- Medicines, including controlled drugs, were stored securely and access was limited to qualified staff employed by the trust. The keys for the controlled drugs were kept separately for increased security.
- The controlled drugs were checked twice per day at shift change over. A register was kept and fully completed. All controlled drugs on the children's ward were in date and accurately recorded.
- Fridge temperatures were checked and recorded daily on the children's ward, outpatient's department and neonatal unit. However, there was no recording of temperature ranges.
- On the neonatal unit we found two bottles of morphine that were past their expiry date, one of which was clearly marked as 'expired.' By keeping medication that had expired on the unit, there was risk it could be given to a baby by mistake. On the neonatal unit, it was noted on five occasions that the temperature of the fridge had fallen below two degrees Celsius without any further checks being undertaken as per trust policy. Subsequently staff were not alerted to any concerns if the temperature of the fridges was not within the required range of between 2 and 8 degrees Celsius (the National Patient Safety Agency recommended range). Any change in temperature out of the recommended range could potentially affect any vaccinations in the fridges making them unfit for use.
- Trust data showed that prescription audits had been completed in February, March and May 2015. These measured accuracy of completion of prescriptions and the results were 93%, 87% and 94% respectively.

Records

- Paediatric medical records were paper based and completed by each member of the multidisciplinary team which allowed continuity of care for each child. In the records that we reviewed we saw that each professional had recorded their entries appropriately; documentation was accurate, complete, legible and up to date.
- Records were stored in trolleys within the nursing office on the neonatal unit and in a purpose built storage unit opposite the nurses' station on the children's ward on the children's ward and neonatal unit.

- In the Children's outpatient department 'copy room' we found four large boxes full of patient identifiable data in the form of clinic books, children's assessment unit books and admission and discharge books that were not locked away and were accessible to the public.

Safeguarding

- Policies and procedures were in place for safeguarding adults and children, and staff were familiar with them.
- Staff confirmed they could contact the designated safeguarding lead, safeguarding link nurses, social workers or paediatric liaison if a child was suspected of being at increased risk of neglect or abuse.
- The child or young person's records contained a safeguarding sheet which identified any safeguarding concerns in the family.
- There was a safeguarding folder kept on the children's ward that identified all babies up to 12 months of age where there were any safeguarding concerns. Staff were familiar with this folder and felt that the system worked well. There was no such system in place for children aged 12 months or over.
- The trust completed audits on the use of children and young people's safeguarding trigger tool within the emergency department. The results for December 2014 to June 2015 showed the trust was constantly performing at or above the trust target.
- The trust had an abduction policy which all staff were aware of and were observed to be monitoring all people entering and leaving the ward/unit. However, the policy stated that a simulation test should be carried out on the policy annually but this had not happened for a number of years.
- The trust's safeguarding policy identified that all nursing staff should have safeguarding supervision twice per year. Staff and managers told us this was in place and worked well.
- Safeguarding issues were discussed at safety huddles to ensure all staff were aware of them. We observed a safety huddle where there was good communication in respect of safeguarding.
- Trust data identified that 99% of staff had completed safeguarding children level one training, which was higher than the trust target of 95%. However the completion rates for levels two and three were lower than the trust target at 88% and 80% respectively. For safeguarding adults training the data showed that 99% of staff had completed level one training and 88% had completed level two.

Mandatory training

- Staff received training in fire safety; conflict resolution; health, safety and welfare; equality and diversity; manual handling; information governance; infection prevention; information governance; resuscitation and safeguarding children levels one to three and safeguarding adults levels one and two.
- Staff reported that they were supported to complete their mandatory training and felt they had enough time to complete it.
- Records showed the training completion rate among staff across the children and young people services ranged between 45% and 97%. The topics with the lowest completion rates were moving and handling (45%-66%) and conflict resolution (59%) which was well below the trust's target of 95% completion.
- In addition to mandatory training, staff within the children and young people's service received profession specific training and development days referred to as PANDA (paediatric and neonatal activity development activity).

Assessing and responding to patient risk

- A paediatric early warning tool was used to aid recognition of sick and deteriorating children, which ensured children were seen urgently, if required. The tool used was the children's physiological observation track and trigger system (CPOTTS) and we saw that this had been completed for each child.
- On the neonatal unit there were multidisciplinary safety huddles held every day to ensure a full assessment of each baby on the unit was undertaken.
- Staff told us that medical staff provided prompt support to children and young people in the neonatal unit and on the children's ward.
- The hospital used the North West and North Wales Paediatric Transport services (NWTS), a specialist transport service for critically ill children and neonates transferring from district general hospitals to one of the two paediatric intensive care units (PICUs) within the

North West and North Wales area. The trust could also access clinical advice on the management of critically sick children before they required paediatric intensive care.
- Staff were aware of how to escalate key risks that could affect patient safety, such as staffing and bed capacity issues, and there was daily involvement by ward managers and the matron to address these issues.

Nursing staffing

- There were nurse staffing vacancies within children and young people's services, ranging between 19.8% and -4.0% for the 12 month period 1st June 2014 to 31st May 2015. The most significant staffing vacancies being in the neonatal unit, which was at 9.9% and the children's ward, which was 8.7% at the time of the inspection. There was a 25% nursing staff turnover over for the same 12 month period. Agency and bank staff were used to fill the nursing vacancies. The trust was advertising the nursing vacancies and this was identified on the children and young people's service risk register.
- Nursing safety huddles occurred three times per day. Staff valued these safety huddles and felt it was a good method of updating them during their shift. We observed a safety huddle and found that it was very thorough.
- The children's ward used a staffing acuity tool based on 'Defining staffing levels for children's and young peoples' services (2013) (Royal College of Nursing), which looked at staff to patient ratio on a shift by shift basis. Staff reported this worked well in practice. The staffing establishment was also assessed across the trust and staff were moved according to need. On the days of the inspection we found that staffing levels were in line with the acuity assessment.
- The neonatal unit used the British Association of Perinatal Medicine (BAPM) acuity tool. This equated to one to one nursing in the intensive care unit and one to two nursing in the high dependency unit. This acuity tool also takes into account skill mix. On review of three months of duty rotas, we found that the unit was not staffed in line with BAPM standards. We found the deployment of staff on shift was inadequate between the intensive care unit and the high dependency unit in that nurses were given babies in both areas and therefore spend the majority of their time in the intensive care unit.
- Agency staff were used on the neonatal unit. However, the unit made attempts to cover with agency staff who had experience of working on the unit. All agency staff were orientated to the unit and their training and competencies were managed by the relevant agency.

Medical staffing

- There were medical staffing vacancies within children and young people's services, ranging between 10.7% and -3.6% for the 12 month period 1st June 2014 to 31st May 2015. Locum cover was at 18.7% at the time of the inspection. We were told that two junior doctors on the training scheme. Some vacant posts were covered by locum doctors. This meant there was one remaining vacancy on the junior tier, and one on the middle grade tier of the rota.
- Weekend and night medical cover was provided by a consultant on call, a registrar and a junior doctor. This was in line with BAPM recommendations.
- Staff told us paediatric clinics were frequently cancelled with less than six weeks' notice due to the consultant rota and lack of junior and middle grade doctors. Data provided by the trust showed that for the six month period, 1st January 2015 to 30th June 2015 there were a total of 33 outpatient clinics cancelled trustwide (133 appointments) with 21 of these with less than six weeks' notice. The data provided by the trust was only available for trust wide and not for each hospital.

Major incident awareness and training

- There was a documented major incident plan within the children and young people's services that listed key risks that could affect the provision of care and treatment. There were clear instructions for staff to follow in the event of a fire or other major incident. Staff members were aware of how to locate this in the case of a major incident.
- Major incident awareness was not offered to staff as mandatory training. This was only offered as role specific at the time of the inspection.

Services for children and young people

Are services for children and young people effective?

Good

Children and young people were receiving care in line with current evidence-based guidance and standards. Policies and procedures were in place and staff were aware of how to access them. Frequent audits were being completed and subsequent action plans implemented.

Pain scores were completed in all the records that we reviewed but not all records contained the pain assessment tool. Nutrition and hydration were monitored and menus were child friendly and healthy foods were offered. The majority of services were offered seven days per week with the exception of the outpatients department which was a Monday to Friday service.

Evidence-based care and treatment

- Policies and procedures were in place and could be accessed via the trust's intranet. Staff were aware of how they could access them.
- The service used a combination of National Institute for Health and Care Excellence (NICE), British Association of Perinatal Medicine (BAPM) and Royal College' guidelines to determine the care and treatment provided.
- Frequent audits were completed in paediatrics, such as paediatric records, epilepsy, diabetes and prescription completion. Subsequent action plans were implemented. However, data supplied by the trust identified that the paediatric records audit should be completed monthly and this had only been completed in January and May 2015.
- All children had care plans within their medical records. However all the care plans that we reviewed were generic care plans and, although there was a section where staff could write individual issues this was not always completed. We also noted that care plans were not updated as the child's condition changed.
- Appropriate care pathways were in use and were in keeping with the relevant NICE clinical or nursing guidance.
- The neonatal unit was part of the Lancashire and South Cumbria Neonatal Network and the ward manager attended quarterly meetings where best practice was discussed and lessons learned from incidents and complaints were shared across the network.
- The neonatal unit was in the process of working towards the Bliss baby charter. The Bliss baby charter is a guide to help hospitals provide the best possible family-centred care for premature and sick babies. This approach places parents at the centre of their baby's care.
- The trust was not working towards Unicef Baby Friendly status and there were no plans in place to do so. Research recommends Baby Friendly status as the best mechanism to raise breastfeeding rates (Department of Health guidance).

Pain relief

- During our last inspection it was identified that pain assessments were not being completed but analgesia was given. We found considerable improvement in this area; in all of the records we reviewed pain assessments had been consistently completed. However not all notes contained the assessment tool.
- Non-medication interventions for pain relief were also used, including comfort holding for babies and use of the play specialists for distraction techniques.

Nutrition and hydration

- Breastfeeding audits were completed on the neonatal unit. This involved mothers being asked to complete a breastfeeding questionnaire prior to discharge and included questions such as what support and facilities were offered to them. The results were subsequently used to shape future improvements on the unit, for example, new breast pumps had been purchased to replace the older breast pumps. Also new screens were purchased as the audit had identified that privacy had been an issue when mothers were expressing breast milk.
- On the neonatal unit there was a 'milk room' where there was a designated fridge for expressed breast milk. This was seen to be clean and organised with trays that clearly identified each baby on the unit and stored the expressed breast milk. However, neither the milk room nor the fridge was locked meaning there was open access to anybody on the ward with the potential for the milk to be unknowingly tampered with.

- The national neonatal audit identified that 31.3% of babies were receiving breast milk on discharge from the neonatal unit which was lower than the national average of 59%.
- Parents told us there was a good selection of food on the menu. Children were also offered snacks and food was available as it was required.

Patient outcomes

- The rate of emergency readmission within two days of discharge for non-elective paediatrics under one year old was 3.8% and between 1-17 years was 3.3%. These were similar to the England average. However for paediatric diabetes the readmission rate was 14.9% which was worse than the England average.
- The rate of multiple (two or more) emergency admissions within 12 months among children and young people with asthma was 17.3% between January 2014 and December 2014 which was slightly worse than the England average. The trust had an action plan in place to make improvements in the management of children with asthma following an audit completed in November 2014. The action plan identified that there should be clear guidance about follow up, continued consideration of prophylaxis and every child should continue to be given a wheeze/inhaler plan.
- The trust completed a paediatric asthma audit in November 2014 which showed that 61% of children presenting with asthma symptoms were managed in the children's assessment unit which was much better than the national figures of 29%, meaning there were less admissions to the children's ward. The audit also showed that of the 55% of children that required a follow up appointment, 40% were followed up by the hospital and only 15% of children were advised to see their GP compared to 40% nationally.
- The trust completed an audit looking at atopic eczema in children between 1st February 2014 and 31st August 2014. The NICE audit support document standards were used to complete this audit. The 100% standard required to meet the NICE guidelines for atopic eczema was not met for any of the standards. An action plan was in place and the trust had plans to complete a further audit in March 2016. Action had been taken to improve the documentation on the computer system in respect of coding of atopic eczema.

Competent staff

- Trust data showed that 94% of medical staff and nursing staff bands one to seven had received their appraisals. This was better than the trust target of 90%. Both band 8a staff that had line management responsibility had received their appraisal. The trust target for this was 100%.
- The children and young people's service was looking to recruit to a band six clinical education post to complement the paediatric practice educator that was already in post. The neonatal unit was in the process of recruiting to a band eight neonatal practice educator. However the post had been advertised three times with no successful applicants being appointed.
- No structured clinical supervision sessions were taking place at the time of the inspection. Staff or managers were not aware of any plans for this to be implemented. The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice. At the time of the inspection staff were doing informal supervision between their peers or with their manager.
- Paediatricians had undergone regular appraisals and information supplied by the trust showed that 94% of medical staff appraisals had been completed.
- We saw evidence that nursing staff had raised concerns about some locum doctors in respect of their skills. However we saw no evidence that action had been taken as a result of the concerns raised and staff that we spoke with confirmed that they felt no action had been taken.
- Trust data showed that 55% of eligible nursing staff on the children's ward had completed the advanced paediatric life support training. This was a rolling programme commenced in September 2014 for nursing staff. The data also showed that 75% of medical staff had completed this training.
- The paediatric ward staff worked hard to provide appropriate care for children and young people with mental health needs but were not specifically trained or experienced in meeting the needs of these patients. This had been highlighted by the service and training had been planned within some key mental health areas affecting young people, for example eating disorders, female genital mutilation and self-harm.

Services for children and young people

Multidisciplinary working

- There were examples of good multidisciplinary team working across the children and young people's services. We attended the multidisciplinary safety huddle on the neonatal unit, which took place daily. This ensured all professionals involved with the baby were fully informed of their care and were involved in decision making.
- The ward rounds were attended by a multidisciplinary team and reviewed each child. Discussions were documented in the medical notes.
- There were two play specialists in post who were experienced within their role and worked over all areas of the children and young people's services. However, this service was only available during weekdays.

Seven-day services

- Paediatric consultants deliver evening shifts between Monday and Thursday until 21.30. During these hours the consultant is supported by a junior doctor on site and a second consultant on call from home. After 21.30 (Monday to Thursday) and after 17.30 on Friday there is a middle grade doctor and junior doctor on site out of hours, supported by a consultant on call from home. There is a daily consultant led ward round at weekends with the middle grade and junior doctors supporting.
- There were seven-day services within the paediatric services with the exception of day surgery and outpatient clinics. Ward clerks and play specialists were available five days per week. The paediatric outpatient department operated from Monday to Friday.
- Paediatric nurses rotated onto the emergency department between 9am and 10pm seven days per week. They did not provide cover overnight. However outside of these hours paediatric nurses from the children's ward are available for advice and support, and to attend the emergency department when required.

Access to information

- Policies and protocols were kept on the hospital's staff intranet so all staff had access to them.
- Medical records were kept on the ward and were accessible to all staff that were involved in the child's care. All staff documented in these records to ensure that they reflected current care received.
- When children were discharged, health visitors were notified to ensure continuity of care.

Consent

- Consent was obtained from parents for each child or young person. Staff were aware of the appropriate procedures in obtaining consent. We saw staff talking to and explaining procedures to children in a way they could understand.
- During our last inspection it could not be established if Fraser guidelines (used to help assess whether a child has the maturity to make their own decisions and to understand the implications) were being followed. However, within this inspection, it was clear during discussions with staff that they used the principles of the Fraser guidelines when making decisions about young people's ability to consent to procedures.

Are services for children and young people caring?

Good

Parents, carers and children were positive about the care and treatment provided. They felt supported, involved in their child's healthcare and received information in a manner they understood. Staff were compassionate, kind and respectful whilst delivering care.

Staff were child and family-focused and they looked at the family unit when completing their assessments. Good interactions were observed between staff and children, young people and their families. Medical ward rounds were completed with only the relevant parent or carer in attendance to ensure privacy and dignity.

Compassionate care

- Children, young people, their families, relatives and representatives were positive about the care and treatment provided by staff. Patients and those close to them were happy and relaxed in the department and staff interacted well with them.
- During conversations with staff it was clear they were very sensitive to parents' needs and supportive when helping them come to terms with their current medical situation.

Services for children and young people

- The NHS friends and family test for children and young people's services showed 94% of parents and children were likely to recommend the services to their friends and family. The friends and family test was introduced in 2013 and askspatientswhether they would recommend NHS services to their friends and family if they needed similar care or treatment
- The 15 step challenge had been completed in the emergency department which identified staff were very caring and positive with good communication.

Understanding and involvement of patients and those close to them

- Parents told us that staff listened to what they had to say and involved them and their children where possible, in the care and treatment of their baby or child. All parents said they were kept well-informed by staff.
- On the neonatal unit, medial ward rounds were done with the parents present so they were fully involved in the care and treatment of their baby. During the ward round all other visitors were asked to leave the room to ensure confidentiality.
- Parents were encouraged to stay with their child both on the neonatal unit and the children's ward. On the children's ward there was no room where parents could access to stay overnight but they were provided with a camp bed next to their child's bed/cot.

Emotional support

- The trust had developed better links between children and young people's services and the child and adolescent mental health service (CAMHS), which was an improvement from our last inspection. However staff felt that due to the demands in this service there was sometimes a delay in children and young people being seen after they had been referred.
- There was a bereavement support link nurse who supported parents and families. There was also a midwifery bereavement coordinator who had close links with the neonatal unit.
- Parents were involved in developing an end of life care plan for their child where appropriate. We were told of instances where the parents had led on this for their child and had received a lead nurse to support them through this process.
- Staff were able to build relationships very quickly with parents, children and young people. We saw evidence of this in all areas, including the ward, outpatients and neonatal unit.

Are services for children and young people responsive?

Good

Services for children, young people and their families provided care and treatment in child friendly facilities. We saw numerous examples of the way the service was able to meet the needs of children and young people, for example, access to a school service and parents could be with their child at all times. The play specialists were responsive to the needs of children within different paediatric areas of the hospital and provided stimulation to babies on the neonatal unit who did not have frequent visitors. Interpreting services were available as required. Paediatric nurses rotated onto the emergency department every day covering between 9am and 10pm. This ensured that children were cared for by a paediatric nurse and they received child focused care. The service received very few complaints but lessons learned from the complaints they did receive were shared with staff.

At our last inspection we identified there was insufficient child and adolescent mental health services (CAMHS) to meet the needs of the children and young people who required this service. However the trust had completed work in this area and improved links with the service and had also identified training needs with the nursing staff which was scheduled to be delivered later in the year.

Bed occupancy for the children's ward and the children's assessment unit was lower than the national paediatric bed occupancy of 75.9%. However the bed occupancy for the neonatal unit was higher than the national average at 79%. There was no neonatal outreach team due to staffing shortages on the special care baby unit, which subsequently could delay discharge. There was a four week waiting list for blood tests to be undertaken on the day case unit. The trust had identified this issue and was in the process of moving phlebotomy to the outpatients department to clear the waiting list and also to increase capacity on the day case unit.

Services for children and young people

Service planning and delivery to meet the needs of local people

- Outpatient appointments took place in dedicated paediatric facilities. The environment was child friendly with toys available and access to a play specialist if required.
- Paediatric nurses rotated onto the emergency department every day covering between 9am and 10pm. This ensured that children were cared for by a paediatric nurse and they received child focused care. Band six staff from the children's ward rotated onto the emergency department once they had completed the emergency department triage course.
- The children's ward had a mixture of six-bedded bays and single side rooms. Separate toilet facilities were available for children, parents and staff. The ward had a parents' room comprising a seating area and basic kitchen facilities.
- The children's ward had an outdoor play area with age appropriate toys. This area could be seen from the parents' room to enable parents to watch their child.
- The ward housed both a youth room and a play area. Both of these areas were age appropriate with suitable toys and games equipment.
- If there were male and female adolescents needing inpatient care on the children's ward, designated single rooms as well as bays were used. There were separate male and female toilet and bathroom facilities.
- In some areas of the children's ward the curtains were too short for the windows which subsequently did not ensure privacy and dignity to the children and young people.
- The neonatal unit was a local neonatal unit and part of the North West Neonatal Network of Lancashire and South Cumbria that included two neonatal intensive care units. Good working and transport arrangements were in place with neonatal intensive care and high dependency units across neighbouring counties as part of the regional transfer network.
- Children's day case surgery took place in adult operating theatres. There was a long walk from the paediatric ward to the theatre and access was via a small lift. This could be problematic if a child's condition deteriorated during their return to the ward.

Access and flow

- There was no neonatal outreach team, although this had been discussed as part of a local initiative. This was not yet at the development stage. This meant that the discharge of neonates could be delayed due to the lack of this service.
- Patients could be referred to the children's assessment unit by GPs and the emergency department, and known patients could have direct access to the unit which allowed for a quicker assessment.
- At the time of the inspection there were 11 babies in outlier hospitals waiting for a neonatal bed at Royal Lancaster Infirmary.
- There was a four week waiting list for blood tests to be undertaken on the day case unit. The trust was undertaking work to move most of the phlebotomy services to the outpatient's department. This would free up space on the day case unit and enable the trust to undertake pre-assessment clinics to be run as this was not available.
- Only a small number of children were transferred out of the hospital with 45 children being transferred to other hospitals between 1st July 2014 and 31st June 2015. However when children were required to move to other hospitals for more specialised care staff told us that the process was very quick and efficient.
- For children and young people that attended the emergency department there were 23 children out of a total of 4352 over a six month period between 1st January 2015 and 31st June 2015 that waited over the Department of Health's guidance of four hours, seven of which waited over six hours.
- Bed occupancy for the children's ward was 59% and the children's assessment unit was 29% for the period 1st July 2014 to 15th July 2015 which were lower than the national paediatric bed occupancy of 75.9%. However the bed occupancy for the neonatal unit was higher than the national average at 79%. The National Audit Office advises that hospitals with average bed occupancy levels above 85% can expect to have regular bed shortages, periodic bed crises and increased numbers of health care acquired infections.
- Staff raised concerns around the length of time taken for discharge medications to arrive on the ward, which frequently delayed discharge. However several strategies were being used in order to prevent this,

including dispensing medications from the ward medications or discharging the child overnight and asking parents to return to the ward the following day for medications.
- Data provided by the trust showed that the sub-speciality paediatric referral to treatment (RTT) performance for the trust's non-admitted patients ranged between 96.5% and 99.5% for the period January 2015 and June 2015, which was better than the trust threshold of 95%.

Meeting people's individual needs

- Translation services were available if required. There were posters displayed in prominent areas around the children's areas to notify parents and carers of the service. Literature was available in different languages.
- At the last inspection it was noted that there was insufficient CAMHS service to meet the needs of the children and young people who required it. Although there were some improvements evident, there was still a shortage of CAMHS support available. The improvements included CAMHS contacting the ward on every week day to establish if any young people required their input and to offer support. Also the ward had arranged for training to take place on issues such as eating disorders, female genital mutilation and self-harm to enable staff to care for these young people more effectively. In addition staff utilised an agency to provide one to one support for young people who were at risk of self-harm when required.
- The ward had access to a school service on the children's ward. Children who were in hospital longer term had access to a teacher. Where the child was able to, they could attend the school/youth room to make sure they did not fall too far behind in their learning.
- The play specialists were responsive to the needs of children within different paediatric areas of the hospital. They told us they were frequently asked to support children and young people in the emergency department, outpatient clinics and theatres. The play specialists also provided stimulation to babies on the neonatal unit who did not have frequent visitors. Children and parents were very complementary about this service.
- The neonatal unit had three rooms that could be used for mothers to stay on the unit to be close to their babies and also to prepare them for the baby's discharge home.
- On the neonatal unit additional support was put in place for parents with learning difficulties. This support included multidisciplinary team meetings and support from a voluntary organisation that supported mothers on the unit.
- Paediatric day case surgery was carried out in adult operating theatres which were not child friendly. Recovery nurses were not specifically paediatric trained. Children were put in the same recovery room as adults with a screen to separate them. Parents were not allowed into the recovery room in the initial stages of recovery, but were allowed once children were aware and could walk their child back to the ward.

Learning from complaints and concerns

- Out of a total of 319 complaints received by the trust for the period 1st June 2014 to 31st May 2015 only six related to the children and young people's division.
- Lessons learned from complaints were shared at safety huddles and then stored in a folder where each staff member was expected to sign to identify they had read it.
- Information was displayed in all wards and departments explaining how parents, children and young people could raise their concerns or complaints.
- Staff were aware of the complaints process. Staff told us they would always try to resolve any issues immediately. If issues could not be resolved, the family was directed to the complaints process. Staff were aware of any complaints made about their own ward or department and any subsequent learning.

Are services for children and young people well-led?

Requires improvement 

There was a departmental risk register in place and staff were aware of the identified risks. This was up to date and reviewed regularly. However for patient safety incidents, a rapid review was completed for significant incidents and a decision was made by senior managers as to whether a root cause analysis investigation was required. Subsequently we found that root cause analysis investigations were not completed for all serious incidents.

Services for children and young people

There was some confusion around the responsibility for a new neonatal resuscitation trolley on the delivery suite and at the time of the inspection, this was not being checked or potentially used due to this confusion. When we raised this with managers it was clear that a process had not been identified or agreed on either prior to the resuscitation trolley being put into use or at the time of the inspection. Subsequently the risks associated with this had not been managed. There were no formal paediatric job plans in place. However we were advised by the trust that they were in the process of constructing these. There was a high staffing turnover within the 12 month period of 1st June 2014 to 31st May 2015, which was 15.3% for medical staff and 25 % for nursing staff. Staffing levels within the children and young people's service was on the corporate risk register as a very high risk and there was an ongoing recruitment drive to address the matter.

Staff were aware of the trust's values and these were displayed in a number of areas that we visited. Nursing staff told us their managers were visible and approachable. There was a monthly paediatrics divisional audit progress report and a divisional and governance assurance report, issues that were discussed included sickness absence, staffing levels, patient safety incidents and lessons learned.

Vision and strategy for this service

- The trust values were displayed in a number of areas that we visited. The children and young people's strategy was based on the trust's vision and staff were aware of the trust's vision and values. However one senior nurse told us they had experienced difficulty in finding the service's vision when completing a member of staff's appraisal earlier in the week.

Governance, risk management and quality measurement

- The service had a departmental risk register and we found that staff were very aware of what the identified risks were. This was up to date and reviewed regularly.
- The division undertook a 'rapid review' for all incidents classed as moderate, major or catastrophic. This involved the ward manager or matron reviewing the case notes and feeding this into a weekly patient safety summit held by the senior leadership team. A decision was made at this meeting whether a root cause analysis was required. Subsequently we found that not all significant incidents were subject to a thorough investigation where lessons learned could be identified.
- There was a monthly paediatrics divisional audit progress report and a divisional and governance assurance report, that reported issues such as sickness and absence, patient safety incidents, training and development, risk register and root cause analysis to the trust's board.
- A new neonatal resuscitation trolley had been put on delivery suite. There was some confusion about who had responsibility for this. The delivery suite staff felt that this was the responsibility of staff from the neonatal unit and the neonatal unit staff felt that they had given responsibility to delivery suite. At the time of the inspection, this was not being checked or potentially used due to these discrepancies. When we raised this with managers it was clear that a process for this had not been identified or agreed on either prior to the resuscitation trolley being put into use or at the time of the inspection. Subsequently the risks associated with this had not been managed.
- Monthly team meetings were held on the children's ward where governance issues were discussed.
- All nursing staff on the children's ward were encouraged to read all identified risks and lessons learned within the ward's daily communication folder and these were also identified within the daily safety huddles.

Leadership of service

- Nursing staff told us their managers and matrons were visible and approachable.
- There was a weekly team meeting attended by matrons, ward manager and senior leadership where agenda items included sickness, audit, training and governance were discussed. This meeting was rotated between Royal Lancaster Infirmary and Furness General Hospital.
- We saw examples of correspondence where nursing staff had raised concerns in respect of the skill set of some junior and middle grade locum doctors. They showed us correspondence of where leaders had identified that it was 'better to have locum doctors than nothing.' We saw no evidence that action had been taken as a result of the concerns being raised

- Consultant paediatricians told us that they felt it would be beneficial to see the clinical director more often. This was also the view of the clinical director as he felt his work load meant that he was not able to spend as much time as he would like to with the medical staff.
- Information supplied by the trust showed that there were no formal job plans that reflected the current working pattern of the consultants. The trust advised that this was mainly due to getting additional resource for staffing levels and they were in the process of constructing formal job plans.
- We found the deployment of staff within the neonatal unit was inadequate between the high dependency unit and the special care baby unit.

Culture within the service

- There was a high staffing turnover within the 12 month period of 1st June 2014 to 31st May 2015, which was 15.3% for medical staff and 25% for nursing staff. Staffing levels within the children and young people's service was on the corporate risk register as a very high risk and there was an ongoing recruitment drive to address the matter.
- Staff placed the child and the family at the centre of care delivery, and how this was seen as a priority and everyone's responsibility. We observed that staff were respectful towards each other, not only in their specialities, but also across disciplines.
- There was good staff morale within each area of paediatrics. Staff told us that there were good team working relationships between the multidisciplinary team.

Public engagement

- Children and young people were asked to complete the 'iWantGreatCare' questionnaire on a handheld electronic device to enable the ward to gain patient feedback.
- A group of young people were asked to complete the '15 steps' challenge on the emergency department. Improvements that were identified included making the children's room more colourful, better identification of waiting times and more magazines for older children. The 15 Steps Challenge is a tool to help staff, patients and others to work together to identify improvements that will enhance the patient experience. The challenge is a ward walk-around, seeing the ward through a patient's eyes.

Staff engagement

- Staff received a regular newsletter which they told us they valued. The newsletter kept them informed of governance issues and trust strategy.
- On the neonatal unit there had been two engagement meetings with staff looking at areas for improvement within the service. Suggestions had been made by staff and work was being completed with implementing these changes, including changes made to babies' identity bands and reductions to visiting hours for all visitors other than parents.

Innovation, improvement and sustainability

- Frequent audits took place within the children and young people's service which were evaluated and plans were put into place to enhance service improvement.

End of life care

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

End of life care services at Royal Lancaster Infirmary (RLI) for the purposes of governance reported through the medicine division. Patients with end of life care needs at RLI are nursed on the general wards. The hospital consultant led Macmillan specialist palliative care (SPC) nurses are ward based and they develop treatment plans and symptom control for the patients which the general nursing teams then deliver. An important function of the SPC nurse team is the management of complexity.

The trust has a bereavement team who provide care and support to relatives following the death of their loved ones. In addition there are well established links with voluntary and charitable organisations providing hospice care, counselling and bereavement support.

There were 1,261 deaths across the trust's three sites, Royal Lancaster Infirmary, Furness General Hospital and Westmorland General Hospital in 2014. There had been an increase in the number of patients who are currently identified as requiring end of life care. The SPC team received referrals from 896 patients from April 2014 to January 2015. Of these the majority (67%) of new patients referred to the service in 2014/15 had a diagnosis of metastatic cancer, however the referrals from non-cancer patients had increased by 8%. This showed the specialist palliative care services were provided mainly to an increasing number of non- cancer patients.

We visited the RLI as part of our announced inspection on 15 July 2015. During this inspection we visited seven inpatient wards; wards 20 and 22 (elderly care), 23 (stroke), 36 (trauma), 37 (respiratory), 39 (stroke, gastroenterology, oncology and cardiology care) and acute medical unit (AMU) where end of life care was being provided. In addition we visited the spiritual centre, bereavement office, the discharge lounge, hospital mortuary and the viewing room.

We observed care, looked at records for 12 people and spoke with patients, seven relatives and 34 staff across all disciplines, including doctors, nurses and health care professionals. We also spoke with members of the management team, porters, chaplains, bereavement team, engagement officer, PALS and mortuary staff.

We also spoke with the three specialist palliative care nurses, the clinical lead for palliative care and the palliative care consultant. In addition we followed and observed the work of an SPC nurse who provided treatment and symptom control for patients, support and advice for staff, patients and their relatives at the hospital.

We looked at appropriate policies and procedures as part of our inspection of this service. We received comments from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

End of life care

Summary of findings

At the previous inspection in January 2014 we rated the hospital as good for the provision of end of life care. Areas identified for improvement were around the variation in the standard of records in relation to do not attempt cardio-pulmonary resuscitation documentation (DNACPR) and a range of syringe drivers were being used in different areas which was a potential safety hazard. The service was awaiting revised documentation following the withdrawal of the Liverpool Care Pathway. In addition there were concerns the specialist service was available during normal office hours only.

As part of this inspection we found improvements had been made in a number of areas. A replacement advanced care plan had been piloted across two wards and had recently been fully implemented across the trust following a programme of staff training. An audit was completed in January 2015 to check DNACPR documentation. Following the findings of the audit, training had been provided and staff were working on the actions. We did however find some shortfalls in these records particularly around the staff understanding and awareness of how to assess people's capacity to make decisions. Staff were committed and passionate about providing good quality care. There had been an increase in palliative care consultant cover. Staff were aware of the process for incident reporting and could demonstrate learning from incidents. Staff generally felt supported and valued.

Ward 23 had been successful in becoming one of the first acute hospital wards to receive the Gold Standard Framework accreditation. Arrangements for the management of medications were well planned and executed including the prescription of anticipatory medication. Staff spoke positively about the rapid discharge pathway that enabled patients to be discharged from hospital to home in the last hours/days of their lives. The trust had plans in place to integrate end of life care services into the 'Better Care Together' strategy. The nursing and medical staff were working with primary and secondary health care professionals to adopt nationally recognised best practice tools, including the GSF, preferred place of care, priorities for care for the dying person and the advanced care plan.

It was clear the trust were working hard to embrace partnership working. The timeline for implementation was slow, two fixed term nursing band 6 educator posts had come to an end as well as the end of life nursing lead and there was concern regarding the impact this would have on the provision of end of life care services.

End of life care

Are end of life care services safe?

Good

Staff said they were encouraged to report incidents and they were knowledgeable about the incident-reporting process. Learning from incidents took place within the specialist palliative care (SPC) team at meetings and for staff at ward level. Anticipatory end of life care medication was prescribed appropriately. Since the last inspection there was now consistency in using the same equipment to minimise the risk of errors. Training for equipment used specifically by the SPC team; such as syringe drivers had been rolled out to staff across the trust. Staff were clearly aware of their role and responsibilities in relation to safeguarding.

The staffing level for the SPC team was generally sufficient to meet the needs of patients however if the service was to become a seven day service additional staffing would be required. It was noted medical cover had increased since the last inspection however there was a palliative consultant medical staffing vacancy which was recorded on the trust risk register. Despite the post being at Furness General Hospital, this had an impact on the provision of the service throughout the trust.

Out of the twelve DNACPR forms we reviewed, six had been completed appropriately. We saw some clear record keeping on the forms and in patients' notes of the reason why the decisions were made, with involvement of the patient or a family member and the involvement of an appropriate clinician. Some of the more minor shortfalls we noted included: gaps in timing between junior doctor and consultant's signature, no record of the GMC number for the junior doctor and no use of an identity stamp.

Incidents

- Staff said they were encouraged to report incidents and they were knowledgeable about the incident-reporting process. Staff could recall incidents they had reported with reference to end of life (EOL) care issues. One example was in relation to poor communication with a patient's relative. Staff had since attended the 'Sage and Thyme' study day to improve their communication skills at this difficult time.
- Specialist palliative care (SPC) staff told us of a monthly newsletter, which outlined lessons learnt from incidents.
- Mortuary staff said they would complete an incident form if they had any concerns regarding either the moving and handling or presentation of a deceased patient or regarding correct identification procedures.
- Staff reported they received feedback and were alerted to any themes from incidents. Minutes from the EOL operational group showed staff were encouraged to report a clinical incident including if a patient was unable to be discharged due to unavailability of nursing home beds.
- Staff confirmed they attended ward meetings and multi-disciplinary meetings where issues relating to incidents were reported. On ward 39 staff gave us an example of where practice had changed as a result of incident reporting. This related to specific training provided for staff in the management of central catheters (A central venous catheter is a long, thin, flexible tube used to give medicines, fluids, nutrients, or blood products over a long period).
- Medical staff demonstrated an understanding of their individual responsibilities in relation to the duty of candour. This involved medical staff being supported to be open and honest with patients and apologise when things go wrong. Incident reports included a prompt to remind staff to send a duty of candour letter where appropriate. The Duty of Candour is a regulatory requirement. The aim of the regulation is to ensure trusts are open and transparent with people who use services and inform and apologise to them when things go wrong with their care and treatment.
- SPC staff attended mortality reviews and despite the target for reviews being 50% the team tried to review every patient to establish any learning.

Medicines

- Anticipatory medication was prescribed appropriately. We reviewed five medication administration record charts across a number of wards we visited and saw appropriate prescribing. Staff followed the policy and managed controlled drugs in accordance with the controlled drugs regulations 2013.
- Medical staff said they followed the trust's clinical guidelines on anticipatory medication prescribing. In addition they were provided with advice and support from the specialist nurses.

End of life care

- Nursing staff said they felt EOL medication was well managed and patients received effective symptom control. On Ward 23 we observed medication was administered for a patient experiencing breakthrough pain in line with their medication chart to relieve their symptoms. Anticipatory medicines were prescribed as patients were identified to be nearing the end of their lives and the pharmacy responded to requests in a timely way.
- In 2011, the National Patient Safety Agency recommended that all graseby syringe drivers should be removed by the end of 2015. Since January 2015 new syringe drivers were available to deliver subcutaneous medication. Staff said each ward was assigned two syringe drivers and they could access a syringe driver when prescribed. This included for those patients who were being discharged home.
- Training for the use of the new McKinley syringe drivers had been rolled out to staff across the trust and advice from the SPC team was provided as required.
- One of the SPC nurses was due to complete a course where they would be granted supplementary and extended prescription rights and two of the other nurses were already nurse prescribers. Ward nurses discussed medication changes with the doctors when advice was not sought from a SPC nurse.
- On Ward 39 we saw anticipatory medication was prescribed in a timely manner, leading to relief for a patient who was in pain. Advice had been sought from the SPC nurse prior to this decision and alternative medications had been prescribed.

Records

- Work has been undertaken by the trust following the review of the Liverpool Care Pathway (LCP) and the decision to withdraw it in July 2014. Guidance was available for staff called 'Best care for the dying patient' until all wards/clinical areas were using the new care of the dying patient' (care plan introduced by the trust).
- Joint working with The North East partnership led to the new 'Care of the dying patient' (CDP) care plan. This was trialled on two wards and had recently been rolled out across the trust. Since April 2015 and the introduction of the new CDP care plan, 19 had been used at the hospital. We were unable to locate any patients who were using the new CDP care plan during this inspection, where death was anticipated.
- All of the twelve care plans we looked at to assess and record patients' EOL care needs reflected national guidance. These records provided sufficient information for staff to provide safe, effective care. Records included completed risk assessments for example, falls, nutrition and pressure relief.
- An orange sticker system was in place which highlighted when the SPC nurses had recorded in a patient's notes. This was to minimise the risk of information not being seen by all staff. Identity stamps were used in the majority of patients' notes by medical staff in line with recommendations from the General Medical Council (GMC).
- In January 2014 the trust introduced the 'Deciding right' DNACPR (do not attempt cardio-pulmonary resuscitation) form which was being used across North Lancashire and Cumbria in line with guidance published by the GMC.
- Records were a combination of paper based and electronic records. A case note audit of the decision making documentation was completed by the trust in February 2015. Out of 132 patients with a DNACPR in place, only 50 patients had information recorded on the electronic health record relating to EOL care. This audit highlighted the need to improve the electronic information recording and sharing, which was starting to be addressed at the time of our inspection. Improvements to the clinical note recording on the electronic record would enable the information to be shared with the GP's palliative care register.
- We found minor shortfalls in six out of 12 DNACPR forms we reviewed. There was clear record keeping on the forms and in patients' notes around the reason why the decisions were made, with involvement of the patient or a family member and the involvement of an appropriate clinician. Some of the shortfalls we noted included: no record of the GMC number for the junior doctor, gaps in timing between junior doctor and consultant's signature and no use of an identity stamp. Medical staff were able to describe the procedures for DNACPR forms and told us they had received 'refresher' legal training in December 2014. Relatives of end of life patients told us their relatives' resuscitation status had been explained to them prior to completion of the DNACPR.
- The trust acknowledged the need to ensure training was ongoing to ensure staff were consistent in completing these forms.

- Patients' records were stored securely on wards to ensure access was appropriate.
- Recording systems were in place in the mortuary to ensure patients were admitted and kept appropriately.

Safeguarding

- There were adult safeguarding policies and procedures in place. Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse.
- Staff on all of the wards we visited confirmed they had attended mandatory safeguarding training for both vulnerable adults and children.

Mandatory training

- Staff in the SPC team were up to date with their mandatory training. Mandatory training included a care of the dying study day which included a bereavement section and a one hour 'Overview of care of the dying' session.
- Staff training and education for managing the care of patients at the end of life had been provided on an ongoing basis by the SPC team.
- Electronic educational packages with learning on DNACPR, advanced communication skills, palliative care and oncology were readily available. This training was mandatory for junior doctors and band 5 nurses caring for oncology patients. Senior staff were able to monitor the staff who had completed this training to ensure learning was being implemented. There was some concern raised by the SPC team, doctors and ward staff that this training should be mandatory throughout the trust and was not.
- We spoke with two bereavement officers who advised us part of their role was speaking with relatives about tissue donation. The staff told us some training in 'difficult conversations' may make them feel more confident and positive around this sensitive subject.

Assessing and responding to patient risk

- Staff used an early warning scores system to alert nursing and medical staff that the patient's condition had deteriorated. Patients' documentation would be transferred to a care of the dying care plan when it was recognised that the patient was expected to die within hours or a few days.
- A system was in place to identify patients by use of a discreet symbol on the electronic board who were for example, at the end of life. Staff showed a mixed understanding about these symbols on the wards we visited.
- Ward staff had contact details for the SPC team and confirmed the team responded promptly when needed.

Nursing staffing

- Staffing for EOL care was the responsibility of all the staff across the wards and not restricted to the SPC team. The SPC team included a lead nurse, two clinical nurse specialists and a band 6 nurse, specialist development post. Staff told us their workload was manageable.
- Ward staff told us they always prioritised care for a patient who was at the end of life and did what they could to ensure a staff member was with them.
- The wards lacked link nurses for EOL care which may impact on the trust's ability to ensure staff received up to date information. Staff in this role would have training and development links with the SPC team. This role had ceased due to lack of continuity in staff on the wards.
- Handovers to discuss patients and caseloads were held twice a day involving two SPC nurses and the consultant when possible. Other staff who attended regularly included the GSF co-ordinator, bereavement officer, physiotherapist and nurses. Handovers included regular meetings with the oncology staff team to discuss patients. Staff confirmed medical and nursing handovers were effective.

Medical staffing

- Specialist consultant palliative care advice and support at the Royal Lancaster Infirmary (RLI) was available from a full time consultant who covered five sessions per week and a part time consultant for two sessions per week. In addition both roles included cover at St John's hospice. The recent appointment of a medical director at St John's hospice had enabled the full time consultant to spend more time at the RLI. The SPC medical and nursing team had a daily update whereby patients referred to the SPC team were given a plan of care which could then be communicated to the patients.
- In July 2015 the consultant told us of their plans to present a 'Case for Change' in response to the National

care of the dying audit in acute Hospitals (NCDAH) published in May 2014 regarding the provision of specialist palliative care advice and support being available at least from 9am to 5pm, 7 days per week.
- The 'Better Care Together' strategic plan included a business case for an additional consultant which would enable seven day specialist palliative consultant services across Morecambe Bay.
- The specialist consultant team operated a 1:3 on call cover service offering specialist advice and treatment plans. A specialist palliative care telephone advice line for out of hours was provided by the local hospices.
- One locum doctor told us they had been in the trust for four weeks. They had completed online training and had the opportunity to shadow another medic when they initially came to the hospital; however they had undertaken no formal induction.

Major incident awareness and training

- There was a trust major incident plan which listed key risks that could affect the provision of care and treatment.
- There were clear instructions in place for staff to follow in the event of a major incident.
- Staff we spoke with were aware of the plans and described the action they would take in the event of a major incident.
- In the event of a major incident, the mortuary had a policy for staff to consult. The senior technician for the mortuary talked with us about these arrangements. The trust had additional space that could be cooled in the event of a surge in demand for refrigerated mortuary space, such as following a major incident.

Are end of life care services effective?

Good

Interim guidance had been in place following the removal of the Liverpool Care Pathway nationally in 2014 and a replacement care plan had recently been agreed via a cross organisational group. Training was being delivered across the trust. This meant work was being done to look at a multi-disciplinary approach to EOL care in all settings. Ward 23 had gained the Gold Standard Framework (GSF) accreditation and plans were in place for GSF to be embedded in the organisation, with accreditation to be achieved on another three inpatient wards over the next two years. The trust supported patients to be discharged to their preferred place of care either through fast track discharges to their home, a nursing home or hospice.

The trust contributed to the National Care Dying Audit Hospitals (NCDAH) to compare end of life care provision with that of other healthcare providers. In 2013/14 the trust did not achieve 6 of the 7 organisational KPIs in the NCDAH and the trust performed worse than the England average in the NCADH for 7 of the 10 clinical indicators. However, there was evidence to show that actions for improvement had been undertaken. Concern was raised that the SPC team would struggle to meet the response times to patients if they were stretched further to seven days a week, particularly due to the increasing number of patients now identified as being palliative or end of life. Following an audit of the DNACPR forms we found staff understanding of assessing people's capacity to make decisions about their care and treatment varied.

Evidence-based care and treatment

- The trust had responded to the withdrawal of the Liverpool Care Pathway with the 'Best care of the dying' guidance as an interim position. A replacement tool (Care of the dying patient care plan) had been agreed via a cross organisational group and training was being delivered.
- The trust had been piloting two versions of the 'caring for the dying patient' care plan since January 2015. The current version had been condensed by the strategic clinical network development team and adapted for use. There were plans for the care plan to be audited in 2015-16.
- The SPC team were working in line with NICE (National Institute for Health and Care Excellence) guidelines to provide the EOL service.
- Policies and procedures were available for staff on the intranet including guidance on best care for the dying patient, Gold Standard Framework (GSF) and links to hospices.
- The SPC nurses had access to current, relevant literature and used evidence-based research to underpin their clinical practice. Two of the nurses explained they were actively involved in EOL research and were looking at palliative skills around communication and mindfulness for patients recently diagnosed with cancer.

End of life care

- The trust were working towards an independent accreditation standard. In December 2014 ward 23 was successful in becoming one of the first acute hospital wards to receive GSF accreditation. Plans were in place for GSF to be embedded in the organisation, with GSF accreditation to be achieved on all adult inpatient areas.
- We saw clear guidance displayed on the notice board of ward 23, where they had received GSF accreditation, explaining the GSF and what this meant in practice for patients and relatives. Staff were familiar with the GSF EOL pathway and this guided them through the process as to the action they should take for patients.
- The trust was not currently auditing the preferred place of care. The new care plan showed the preferred place of care wishes of patients could be ascertained therefore this could be monitored in the future.

Pain relief

- Providing effective pain relief for patients receiving EOL care was a critical part of the SPC team's role. In 2013-14 SPC staff had attended courses in advanced pain, symptom control and non-medical prescribing to ensure patients received appropriate advice.
- Appropriate medication was available for the ward staff to use and we saw that anticipatory prescribing was managed well. Pain relief was monitored for efficacy and was adjusted to meet patients' needs.
- An internal report on the 'Introduction of the care for the dying patient' care plan showed all the doctors who completed these confirmed they had prescribed the 'just in case' drugs for symptom management for all the patients where the new care plans had been used. This showed this aspect of patient care was now well embedded in practice.
- Doctors confirmed they were aware of the guidance available to them and were familiar with contacting the SPCT for advice.
- The National Care of the Dying Audit of Hospital (NCDAH) 2013/2014 showed that 58% of patients at the trust had medication prescribed 'as required' for the five key symptoms that may develop at the end of life. This about the same as the national average for England which was 51%.
- Following a pharmacy department opioid audit in 2013/2014, an update was made to the trust standard operating procedure, a patient information leaflet and an audit of opioid prescribing was carried out. This showed the trust were taking appropriate action to improve.
- The new care plan included a 'pain core care plan' which prompted staff to seek medical or specialist palliative care advice if patients' pain remained uncontrolled or side effects were problematic.

Nutrition and hydration

- Care plans included an assessment for oral nutrition and hydration and indicated patients should eat and drink normally for as long as possible despite this need reducing as people approach the end of their life. A mandatory core care plan was included with interventions for staff to appropriately support patients with eating and drinking.
- In the NCDAH 2013/14 the trust's scored 34% for the 'review of the patient's nutritional requirements' indicator which was worse than the England average of 41%. The new care of the dying patient care plan included clear guidance that patients should not be denied food and oral fluids. Staff found using a nutrition and hydration plan for patients' improved multidisciplinary communication between doctors and nurses. Two of the doctors we spoke with confirmed they felt this record was positive.
- The care plan included principles to guide the staff in their ongoing assessment; including ensuring regular mouth care, considering thickened fluids and involving the family or significant others as necessary.
- Patients we spoke with were positive about the availability and choice of suitable and nutritious food and drink and access to regular hot and cold drinks. We looked at the record chart for a patient in receipt of artificial nutrition (a form of life-sustaining treatment whereby nutrients and fluids are provided by placing a tube directly into the stomach, the intestine or a vein.) Staff were able to explain how they managed the patient's artificial nutritional support and they had been assessed as being competent.

Patient outcomes

- In the NCADH 2013/14 the trust did not achieve six of the seven organisational key performance indicators and performed worse than the England average for seven of the ten clinical indicators.

- As a result, an action plan had been developed to detail how the recommendations made would be achieved. Considerable work was being done where shortfalls had been identified including: provision of the specialist palliative care service, staff training, and patients' nutritional and hydration status, symptom management and patients' spirituality needs being incorporated in the new care planning system.
- The consultant explained a new audit was currently in progress and the previous one was at the time when the LCP had just been withdrawn. They were contributing to this audit at the time of our inspection. The SPC team believed the results would be more favourable than the 2013-14 audits.
- The new 'care of the dying patient' care plan had been introduced in a phased approach to replace the LCP with effect from January 2015. In the weeks of its availability 28 care plans had been used at the hospital. A future audit of its use was planned to assess its effectiveness.
- The trust supported patients to be discharged to their preferred place of care either through fast track discharges to their home, a nursing home or hospice. Two revised discharge pathways were implemented late in 2014: red for patients whose condition is rapidly deteriorating and the patient has a preference for care outside the acute hospital and amber for patients whose increasing decline is recognised. The patient and family were involved in the full process to facilitate a reduced length of stay and enable care in the place of their choice; ensuring discharge was supported and safe. The SPC team provided guidance and support as required.
- Monitoring of the discharge pathways since January 2015 was undertaken to evaluate the effectiveness of fast track discharging of patients known to the SPC team to their preferred place of care.
- Since January 2015 there had been 41 discharges using the fast track process across the trust (21 of which were at the Royal Lancaster Infirmary). An action plan had been developed in order to look at how to address issues affecting the timeliness of these discharges. Examples included: care agencies being unable to provide required domiciliary care and furniture needing to be moved to accommodate required equipment. Positive results included a fast track at the weekend, good support from Hospice at Home who sourced a Marie Curie sitting service and improved documentation accompanying the patient.

Competent staff

- The SPC team were well qualified and attended relevant courses to extend and update their knowledge and skills; one example was the lead nurse who had recently attended a palliative care nurses' conference.
- The SPC team confirmed they received monthly clinical supervision to support them in their role and they had received an appraisal in the last 12 months.
- The trust was undertaking the Gold Standards framework (GSF) for acute hospitals training and a training programme was in place to provide ward staff with training in the principles and practice of GSF.
- Staff raised concerns that both GSF co-ordinator posts were being phased out and the training role was now being taken on by the local hospice. We spoke with two GSF co-ordinators who had rolled out the training for the new 'care of the dying patient' care plan to ward staff. It was of concern that these posts were due to end in July as feedback had shown the training empowered staff to be more confident in EOL and with communication skills when a patient was identified as being at or nearing the end of their life.
- All staff in the SPC team undertook the responsibility for training and the development of staff.
- Staff training in care of the dying patient, including awareness and documentation, was being disseminated with 466 staff trained in the last six months at RLI and 315 at FGH. Staff we spoke with on the wards were aware of how to care for a patient who was palliative or at the end of life.
- All fourth year medical students gained experience in the palliative care service.
- The SPC team had clinical supervision to support them in their role and had received an appraisal in the last 12 months.
- The palliative medicine consultants had received an appraisal and were completing their revalidation in line with the General Medical Council guidance.
- Between the three hospital sites 125 nurses had been trained in the verification of expected death. This reduced some work for the medical staff.

- The trust training management system which enabled staff to carry out on line training. A new staff member in the mortuary explained how the local training they completed then fed into a national training programme to develop their career path.

Multidisciplinary working

- The multi-disciplinary team (MDT) worked well together to coordinate and plan the care for patients at the end of life. The hospital palliative care team held weekly MDTs. Attendance mainly consisted of nursing and medical staff from the hospital, community and hospices.
- In addition daily MDT meetings were held on the medical wards to discuss and manage patient risks and concerns. Patients at the end of life were included in this discussion so all disciplines could contribute to effective and consistent care for these patients.
- There was access to non-specialist physiotherapy and occupational therapy.
- The speech and language therapist did not attend MDT meetings routinely however they were in frequent contact with the nurses to provide guidance and advice.
- Requests for input from the SPC team were made by the ward staff.
- The 12 patients' care plans we looked at showed evidence of input from regular multi-disciplinary team meetings. On Ward 39 we observed the team meeting with a patient's relatives. Staff had spoken with the patient who preferred to move to the local hospice. A referral was made and appropriate conversations were held with the staff and relatives involved.
- The chaplains visited the wards daily and received referrals from staff for any specific requests. The chaplain would provide spiritual or general support as requested from the patient.
- The SPC team worked closely with respiratory, breast, cardiology and stroke specialities. The team have strong relationships with cancer and non-cancer specialists and the acute oncology team.

Seven-day services

- Plans for the future included a business plan to access seven day specialist palliative care face to face consultation and 24 hour SPC advice.
- The team offered a five day Monday-Friday 8am -6pm service across the trust's three hospital sites. Out of hours there was a hospice hotline provided by nurses with access to advice from consultants on a 1:5 rota 24 hours a day, seven days a week. The consultant worked across boundaries and was part of a seven day a week rota. Concern was raised that the service would struggle if they were stretched further to seven days a week.
- Staff reported there were no issues in accessing diagnostic services which were available 24 hours a day, seven days a week.

Access to information

- The SPC team had provided 'Care of the dying patient training days' and included a bereavement section on this course.
- There was an electronic palliative care co-ordination system (EPAACS) system available but this had not been implemented properly with all potential users and across all sites at the time of our inspection.
- The palliative care website provided information and guidance for staff on the intranet. Information included guidance on referring patients, including those requiring symptom control, links to hospices, medical and nursing assessments, and 'just in case' drugs. Staff we spoke with felt this was a useful resource that was easy to access.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards(DoLs)

- Following an audit of the DNACPR forms we found staff understanding of assessing people's capacity to make decisions about their care and treatment varied. An action plan had been developed in response to the audit to address this issue.
- Training around the mental capacity act including DoLs and best interest decisions had just been delivered to five case workers, safeguarding and discharge leads and two hospital social workers.
- Evidence of training dates were available for nurses and support staff to attend a training day on 'Care of the dying patient in the last days and hours of life'. This programme included the Mental Capacity Act, recognising dying communication and advanced care planning.
- The trust had a consent policy in place. The policy included advanced decisions, lasting power of attorney, mental capacity guidance and the use of Independent Mental Capacity Advocates where necessary.

End of life care

- On two of the DNACPR forms we saw, the patient's mental capacity assessment and best interest decision was recorded on the form itself and in their notes. This included family involvement. In addition, a copy had been forwarded to the patient's GP.

Are end of life care services caring?

Good

End of life care services were provided by caring staff. Staff were sensitive to the needs of patients who were seriously ill. Feedback from people who use the service was mostly positive about the way people were treated. Patients received compassionate care and their privacy and dignity were generally maintained. A minority of people felt their experience could have been better with improved communication between medical and nursing staff and relatives. Additional training in communication had been provided by the trust.

Patients and those close to them were positive about their interactions with the committed SPC team. Patients felt their individual needs were met in a professional, sensitive way. Staff were observed spending time talking with patients and relatives and people were encouraged to be involved in their loved ones care. The staff recognised the importance of the fact that the earlier the identification of patients nearing the end of their life took place the more likely they would receive a positive experience.

There was a purpose built dedicated bereavement office providing a best practice service with regards to providing pre and post bereavement care. The SPC team were committed and enthusiastic about improving end of life care.

Compassionate care

- Staff were caring and compassionate and understood the need for sensitive communication for patients who were approaching the end of life. We observed patients on wards who looked well cared for and interactions between staff and patients were caring and respectful.
- We heard from people who wanted to share their experiences with CQC and we spoke with relatives of patients during this inspection. A small number of people felt their experience could have been made better by improved communication between staff and relatives. One of the recommendations following the 2014 'hospital bereavement experience survey' was the importance of including families in decision making and ensuring regular, clear communication about their loved ones. There was acknowledgement by the EOL co-ordinator of the need for ongoing specialist training in communication.
- Training in communication skills was provided to staff through the 'Sage and Thyme' programme, a foundation level communication skills workshop developed in response to NICE guidance. The SPC team had attended advanced communications training.
- On the wards we saw examples where families were encouraged to participate in aspects of care of their loved one, for example, personal care and mouth care.
- Staff told us of the practical support they were able to provide for relatives, examples included normal visiting times being waived, toiletries provided and free parking made available.
- Patients' records showed discussions of sensitive conversations that had been held with patients and relatives.
- The bereavement nurses were hospital based roles that supported families and carers at the time of death. Bereavement staff had introduced canvas bags that included the dragonfly dignity symbol. The dragonfly symbol enabled staff to identify the person carrying the bag as newly bereaved; and therefore someone who may be in need of extra care and support as they leave the hospital.
- The bereavement office staff told us they contacted each bereaved family and met them when they collected the cause of death certificate and their loved ones possessions from the office. Families were offered the choice of specialist nursing support at this time. The introduction of the bereavement office two years ago had made an improvement in the family's experience at such a distressing time.
- Ward staff reported to us how respectful hospital porters were when caring for deceased patients before they were transferred to the mortuary. Staff treated patients with dignity and respect after their death. We saw that mortuary staff referred to deceased people in a respectful manner.
- Where possible patients at the end of life were provided with a side room; staff told us this was normal practice and we observed this during the inspection.

End of life care

- There was a quiet room on most wards where sensitive conversations could be held and staff confirmed these were used to talk with relatives and patients.

Understanding and involvement of patients and those close to them

- Patients and their relatives felt involved in their care. The named consultant and nurse was written above patients' beds and relatives told us they had been given an opportunity to speak with them.
- There was a section in the new advanced care plan to record family involvement and where staff could record on the communication sheet.
- We observed staff speaking with patients living with dementia in a kind and sensitive way. We were aware medical and nursing staff were consulting with this patient and their relatives to discuss their preferred place of care. Staff spoke of this patient with compassion and sensitivity when describing how they were planning to carry out this discharge.
- A policy was in place to ensure potential tissue donors were identified and referred to the National Referral Centre. As part of EOL care, healthcare professionals were identified as the point of contact for bereaved relatives about donation.

Emotional support

- The new care plan included a section to ensure patients' spiritual needs were assessed and recorded in line with NICE guidance for EOL care.
- The trust were proud of the trust bereavement team who accepted an award at the 2015 'Your health heroes' awards ceremony in February, where the hard work of the team was recognised including the mortuary and chaplaincy departments.
- The hospital scored 20% in the 2013/14 NCDAH for assessment of the spiritual needs of a patient and their nominated relatives or friends. This was worse than the England average of 37%. In the last 12 months the trust chaplaincy service had become more established and was seen as an integral part of the service provided to patients, relatives and staff.
- The hospital had a Christian chaplaincy service that provided spiritual support to patients and those close to them.
- We spent time with the chaplain who informed us that they could call on spiritual leaders from other faiths as necessary to ensure patients religious wishes were adhered to.
- The chaplaincy service had increased from one to three chaplains, with a chaplain on each hospital site providing support to patients, families and staff. This demonstrated a caring and compassionate approach towards patient, relatives and staffs spiritual welfare.
- The chaplaincy had organised a service of remembrance every two months at the hospital which had been well received by bereaved relatives. Some contract funerals had been held for those people with no close family or who could not afford the cost of a funeral.
- We spent time with the volunteer engagement officer. The service had expanded to 140 volunteers across the three hospital sites. This service included specific volunteers to support the emotional needs of patients. Two patients we spoke with spoke favourably of the service provided.
- Emotional support to patients and their relatives was also provided by the SPC team. This was confirmed through conversations with relatives and recordings in patients' notes. Two patient's relatives told us they had been included in discussions and explanations about the progress of their loved ones.
- There was a viewing room where relatives could spend time with their deceased loved ones in the mortuary.
- The NCDAH 2013/14 reported that the trust was below the English average for access to information relating to death and dying. During the inspection we saw information including bereavement booklets were available to guide newly bereaved relatives. Signposting for people to contact other support agencies was available on wards throughout the hospital, for example information about local hospices, a cancer information guide, Marie Curie and the hospice at home service.

Are end of life care services responsive?

Good

End of life care services were responsive to the needs of the local population. The trust had a new strategic plan in place which aimed to improve and connect services to prevent patients having their care compromised with

admissions and readmissions to hospital. The SPC team had a flexible referral process. Ward staff told us the SPC team responded promptly to referrals, usually within 24 hours.

Services were planned to take account of the needs of different people, including people living with dementia. The trust had a rapid discharge service for discharge to a preferred place of care (PPC). There was open access for relatives to visit patients who were at the end of life, and free car parking for those visiting. Access to side rooms was provided whenever possible. Facilities to meet the multi-faith needs of people had improved since the last inspection and the chaplaincy service had expanded. Bereavement services were well organised and responsive to people's needs. The skills and commitment of the SPC teams provided support to ward staff in a responsive and timely way that met the individual needs of patients.

Service planning and delivery to meet the needs of local people

- There had been a three year EOL Commission for Quality and Innovation target (CQUIN - a payment framework which enables commissioners to reward excellence) from 2012-2015, the aims of which were to improve quality of care for people with life limiting conditions and the bereaved. One element of the CQUIN was to implement the Gold Standard Framework (GSF) to coordinate care across boundaries, ensuring consistent use of good practice. The aim was for non-specialist staff to identify patients who may be in the last year/s of life, assess their needs both clinical and personal with the SPC team as necessary. Thus coordinating care across boundaries, ensuring consistent use of good practice.
- To support this approach, GSF training had been provided, identifying GSF, advanced care planning and bereavement. Significant improvement had been made in generalist palliative and EOL care during this time, however staff recognised further and continued training and development was required to embed the cultural change. The team had worked hard with GPs and most were GSF accredited.
- The membership of the existing EOL group had been reviewed to include the trust, North Lancashire and Cumbria provider services and local hospices to create an overarching group. The specialist palliative care cross trust meetings involved the deputy chief nurse and a representative from general medicine, in order to ensure EOL care was important for all staff and not just the SPC team. Consideration may be given to surgical representation at these meetings.
- In response to meeting the needs of local people the chaplaincy had engaged with a local mosque to better understand their needs and what the chaplaincy and bereavement service could deliver to support Muslim families. In addition the chaplains had organised for bodies of deceased patients to be repatriated to countries of origin, for example Pakistan.
- Wards were looking to improve facilities for relatives. For example, staff on ward 39 were in the process of obtaining some fold up beds for relatives to stay overnight.
- There was open access for relatives to visit patients who were at the end of life, and support with car parking for those visiting.

Meeting people's individual needs

- The GSF was used to identify patients early who were likely to be in the final year of life and those patients who are in the last days or hours of life. This ensured a holistic assessment or an advanced care plan to take account of people's individual needs.
- There was an effective pathway for respiratory patients. An advanced nurse practitioner took referrals from GPs and oncologists and had carried out 150 pleural aspirations in two years. This was managed as a day case service in order to make the experience more patient friendly, rapid and cost effective.
- Up to this inspection 28 of the new individualised advanced care for the dying patient documents had been completed from April to July 2015 at RLI. Results highlighted that all doctors prescribed anticipatory medication for symptom management in the dying phase.
- Information about the dementia 'butterfly scheme' was displayed on the notice board to alert staff to patients who may require more support and time due to their condition.
- We listened to a board round on one ward where the staff reviewed the complex planning for discharge for patients. Staff confirmed this promoted effective communication and enabled them to respond to the

needs of individual patients. The 'Hospice at home' service visited wards each week where there were patients who were due to be discharged and they would speak with them on the ward if required.
- Mortuary staff demonstrated their awareness of and sensitivity to cultural and faith practices.
- A version of the bereavement booklet had been translated into polish to meet the needs of local people. This was awaiting final print.

Access and flow

- The SPC team had a flexible referral process. Ward staff told us the SPC team responded promptly to referrals, usually on the same day.
- The SPC team told us their referrals were promoted through them visiting the wards. Staff told us the team always responded in a timely way to requests for advice or to visit the patient.
- The GSF was noted on the inter-ward transfer information. This highlighted to staff that a patient may be in their last year of life.
- Two doctors told us they made referrals to the SPC team however they were not aware of a referral protocol. Despite this their patients were seen and their judgements appeared satisfactory.
- In total the SPC team showed 4128 patient contacts recorded in 2013-14. 65% of hospital patients seen by the SPC team were coded on the GSF, whereby patients identified as likely to be in the last year of life had a holistic needs assessment and were offered an opportunity to plan for their future.
- Not all wards had an identified discharge coordinator. At the time of our inspection, the rapid discharge lead was working on getting a patient who was nearing the end of life home. The oxygen had arrived within four hours; transport was agreed within four hours however the problem was the provision of care staff in the community which was not available for 2-3 days. A discussion was being held with the family to see if they could support the patient until the care package was available.
- The trust had a rapid discharge service for discharge to a preferred place of care (PPC). Following on from NICE guidance, the EOL Strategy (2008) was clear that people at the EOL should be able to make choices about their place of death. The rapid discharge pathway was to support patients to be discharged from hospital in the last hours /days of life. The discharge team had successfully discharged 81 patients on fast tracked continuing health care from July 2015 which demonstrated responsiveness to patients' needs.

Learning from complaints and concerns

- Any complaints were handled in line with trust policy. Information was available to inform patients and relatives about how to make a complaint.
- Any informal complaints would be dealt with on the wards. If necessary people would be advised to use the patient advice and liaison service (PALS). There were few complaints relating specifically to EOL care. The team leader for EOL care would be made aware of any complaints about the SPC service.
- One aspect of the bereavement nurse's role was to identify family concerns and ensure these were resolved in a prompt and timely manner by the most appropriate professional.
- We saw evidence where a complaint had been responded to and where learning was put in place to improve practice**.** Any complaints relating to EOL were discussed at the EOL strategy group and were used for multi-disciplinary teaching.
- A 'lessons learnt' register was created by PALS and shared with staff involved following closure of a complaint.

Are end of life care services well-led?

Good

The clinical director with responsibility for EOL care and the SPC team leader spoke to us passionately about the vision for the service. In 2013 the SPC team developed a comprehensive clinical strategy. This included a plan for one, two and five years ahead. We were told how the five year strategy was developed and the SPC team had a clear vision how to develop palliative and EOL care across specialisms. The new strategic plan aimed to improve and connect services to prevent patients having their care compromised with admissions and readmissions to hospital. There were several examples of improvement and innovative practices that had been implemented to improve the quality of services provided to patients at the end of life.

End of life care

EOL care service leaders were clear on the key risks within the service but the service did not have a specific risk register. This meant that, unlike other services in the hospital, there was no clear, easily accessible overview of the ongoing risks within end of life care services.

Vision and strategy for this service

- The clinical director with responsibility for EOL care and the SPC team leader spoke to us passionately about the vision for the service. In 2013 the SPC team developed a comprehensive clinical strategy. This included a plan for one, two and five years ahead. We were told how the five year strategy was developed and the SPC team had a clear vision how to develop palliative and EOL care across specialisms. The consultant spoke of how the current service was fragmented with several providers of palliative and EOL care across Morecambe Bay and the plans to move to a more community based, palliative service that had been proposed in a business case based on the 'Better Care Together' model. This would link care between the acute, voluntary and community sectors.
- The new strategic plan aimed to improve and connect services to prevent patients having their care compromised with admissions and readmissions to hospital. It was acknowledged that the new service would require an additional consultant to provide seven day cover 24 hours a day and a manageable on call rota.
- Following the NCDAH audit the trust developed an action plan that included identifying a board member with specific responsibility for care of the dying. The trust had addressed this and somebody was now taking on this role.
- The service vision was that people nearing the end of life would have their physical, emotional, social and spiritual symptoms minimised. The palliative and EOL care would be delivered within the context of a multi-disciplinary team who would work together to agree pathways of care which were compliant with national guidance and met the needs of the local population.
- Significant improvement had been made in generalist palliative and EOL care, however further work was required to embed the cultural change of linking care between the acute, voluntary and community sectors.

Governance, risk management and quality measurement

- The SPC team attended 'cross site' governance meetings bi-monthly that encouraged collaborative working and information sharing to the benefit of dying patients and their relatives.
- EOL care leaders were clear on the ongoing risks within the service but the service did not have a specific risk register. The trust stated this was because it did not have a division or department that had, as its primary purpose, palliative end of life care, which would enable easy identification of such risks. This meant that, unlike other services in the hospital, there was no clear, easily accessible overview of the ongoing risks within end of life care services.
- However, the trust did provide a 'risk register' document which identified the concerns related to palliative and end of life care when requested. However, it was not clear whether the actions detailed had reduced the on-going risk rating. The risks were not dated so it was not clear how long they had been on the risk register.
- There were systems in place to audit the quality of end of life services that were regularly reported and monitored from the ward to the board. The monitoring of complaints, incidents, audits and quality improvement projects were raised at board level.
- An action plan was developed as a result of the NCDAH 2013/14 and identified areas that remained ongoing including: provision of an additional consultant, communication skills and education and training in care of the dying being mandatory.
- The SPC team had developed clinical and educational strategies to aid them to remain clear about their objectives.
- Since the last inspection the trust had improved the identification of patients who were identified as end of life through use of clinical data analysis. Patients were identified with EOL alerts on the electronic health record which highlighted patients who were likely to be in the last 12 months of life.

Leadership of service

- The SPC team demonstrated effective leadership and the leaders understood the challenges to provide good quality palliative and EOL care services across Morecambe Bay.
- The trust SPC and EOL team, including bereavement services were employed within the medicine division of the trust, the consultant was the clinical lead for the

trust and Lancashire North CCG and there was an appointed nursing lead. The team held operational meetings and reported through the elective medicine division.
- Ward staff felt that the SPC team were visible and approachable and supported the staff to care for patients at the end of life.
- Chaplaincy services were well-led in that they were organised and well thought out. An annual report reviewed the service from 1 April 2014 to 31 March 2015 which highlighted the achievements and service developments for the year.
- The service was well supported by specialist nurses although there was limited medical input to the SPC team. However there were now three part time consultants, in palliative medicine. We were told this paved the way for the possibility of a specialist registrar training post.

Culture within the service

- The SPC nurses were passionate about their roles. The service was focused on positive outcomes in terms of patient care and experience. Staff were proud of the work they did and were committed to doing the best for patients.
- Staff reported positive working relationships across all disciplines. There was a culture of sharing knowledge and expertise demonstrated through formal training and informal teaching opportunities.
- All staff we spoke with showed a positive attitude towards caring for dying patients.

Public engagement

- The bereavement officer gave out information packs to families when they came in to pick up death certificates.
- Patient surveys had been sent out for those who had been identified as being in the last twelve months of life. The service had not yet analysed the results from this.

Staff engagement

- The service had made improvements with education and communication skills. Staff completed an evaluation following a bereavement care study day and responses were analysed to drive improvement.
- Ward staff told us they felt listened to and the intranet was a useful resource for information.
- Staff in the SPC team had an annual appraisal which they told us worked well and as a small team they had the opportunity to raise and discuss any problems with each other.

Innovation, improvement and sustainability

- The trust had been implementing the GSF over the last two years. Staff at all levels spoke of their anxieties the impact on the demand for the service may have on the EOL team and training provision. A goal was for GSF to be embedded in the organisation, with GSF accreditation to be achieved on all adult inpatient areas. Plans were in place for a further three wards over the next two years to achieve GSF accreditation.
- The staff shared a number of innovative practices as detailed below. One example included the new draft EOL stroke pathway.
- Improvements had been made to the discharge summaries. Other developments included the SPC team sending discharge summaries to patients seen by them. This was in addition to the summary provided by the junior doctors.
- The speech and language therapy team were doing innovative work with food thickener and designing a document around feeding and the risk of choking with EOL patients. Plans to have this information held at the front of the patients' notes for ease of access for staff were being developed.
- Improvement had been made for the provision for transferring bariatric patients to the mortuary on both sites.
- At RLI the chaplaincy had organised a service of remembrance every two months for bereaved families.
- The SPC team told us the introduction of a designated MDT to include occupational therapists, physiotherapists and social workers would further develop the service.
- A fully functional electronic palliative care co-ordinating System (EPACCS) across all relevant sites would enable service providers across boundaries to share information.

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The trust provides a range of outpatient and diagnostic services across its three sites (Royal Lancaster Infirmary, Furness General Hospital and Westmoreland General Hospital). For the period 2013/14 the trust had 512, 694 outpatient attendances (296,701 of these were at the Royal Lancaster Infirmary). In the period 2104/15 this had increased to 520, 602 attendances trust wide. Records we reviewed confirmed that there had been a steady increase in required diagnostic services appointments over the last three years.

The radiology service includes: Diagnostic imaging and reporting across a variety of modalities including CT/MR imaging, Nuclear medicine, Fluoroscopy, Mammography, Ultrasound and General Radiography. The pathology service provides a full range of patient diagnostic and reporting services to support effective patient diagnosis and treatment plans. Blood and analysis services are provided to emergency and theatre areas. The service has a Community Patient Contact Centre (CPCC) which acts as the patient focal point for correspondence, discussions and planning around bookings for their elective appointments. The outpatient service is responsible for the management of room scheduling and staff support to clinicians to enable the running of outpatient based treatment functions within the trust.

We inspected a number of the outpatient clinics and diagnostic services at the Royal Lancaster Infirmary including ophthalmology, rheumatology, physiotherapy and radiology service. We spoke with 12 patients and 29 staff including nursing, medical allied health professionals and support staff. We received comments from people who contacted us about their experiences. We also reviewed the trust's performance data and looked at individual care records and images.

Outpatients and diagnostic imaging

Summary of findings

Since our last inspection we found that there had been some improvements however there were still a shortage of occupational therapists as well as radiologists and staffing shortages in pathology. As part of our last inspection we identified concerns with the timely availability of case notes and test results in the outpatients department. At this inspection staff and managers confirmed that the trust had invested heavily in the medical records storage and provision on site. As a result we found there had been improvements in the availability of case notes.

Space was limited in some areas and the service provision was physically constrained by the existing environment. We visited the physiotherapy department in medical one unit which we found to be cramped and in poor state of repair. Competency assessments were in place for staff working in the radiology department along with temporary staff to the department. However, staff raised concerns about their competencies in CT scanning, due to their rotation into this area being hampered by staff shortages.

Our previous inspection noted that there was no information available in the departments for patients who had a learning disability or written information in formats suitable for patients who had a visual impairment. In the course of this inspection we noted that this was not the case. Main outpatient and the Occupational Therapy department have specific information /leaflets for patients with learning disabilities. Main Outpatients and the Ophthalmology department have leaflets in an easy read formats; or written in formats suitable for those patients who have a visual impairment .

Senior managers told us the service had experienced issues with effective team working and had challenges in building team resilience and communication. We found examples of temporary leadership roles in place that had led to difficulties in driving forward service innovation and improvement. This was a particular issue in the Breast Screening Unit.

Outpatient and diagnostic services were delivered by caring, committed and compassionate staff.

Patients were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes. Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence based and followed national guidance. We found that overall access to appointments had improved but performance was variable.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

The Royal Lancaster Infirmary consisted of multiple buildings spread across the site. Some of the departments were located within the original hospital buildings whilst others were in a purpose built environment. We noted that space was limited in some areas and the service provision was physically constrained by the existing environment. We visited the physiotherapy department in the medical one unit that we found to be cramped and in poor state of repair. We found that this had been put on the risk register but there was no date for remedial action to be carried out.

The trust managers told us that there was an "I've been cleaned" sticker system in operation to inform staff at a glance as to the cleanliness of equipment and furniture. We did not see evidence of this being used universally across all the departments we visited.

At our last inspection we told the trust that it should review its staffing investment to ensure that the allied health professional workforce was developed at the same pace as the nursing and medical workforce to meet the growing demand for services. At this inspection we found there was a shortage of occupational therapists as well as radiologists along with staffing shortages in the pathology service.

As part of our last inspection we identified concerns with the timely availability of case notes and test results in the outpatients department. At this inspection staff and managers confirmed that the trust had invested heavily in the medical records storage and provision on site. As a result there had been improvements in the availability of case notes. The trust had continued to roll out its "Paper Lite" project that ensured that electronic information was available for patients at their consultation. This project was not yet fully implemented but staff were positive about the improvements in efficiency and effectiveness for outpatient services such as the availability of test results and timely access to information. There had also been improvements in the processes for reporting and learning from incidents.

Incidents

- There had been four serious incidents reported between May 2014 and April 2015 across outpatients and diagnostic services. One serious incident involving both the Royal Lancaster (RLI) and Furness General Hospital was in relation to a failure to act upon test results. A full root cause analysis had taken place and the process of feedback and learning was ongoing across the outpatient and diagnostic services at the time of our inspection.
- At our previous inspection we told the trust that it must improve its incident reporting processes and ensure all staff were aware of their responsibilities to report incidents and implement remedial actions and learning as a result. In the course of this inspection we found that staff were aware and understood their responsibilities with regard to reporting incidents. All accidents, incidents, allegations of abuse or complaints were logged on the trust -wide electronic reporting system appropriately.
- Previously we found that performance information and learning from incidents was not effectively used to drive changes and improvement. At this inspection we found incidents were investigated by trained managers. We saw examples of shared learning from incidents to secure improvement and prevent reoccurrence.
- As part of our last inspection we were informed of concerns in relation to the breast screening of patients who had gone on to develop symptomatic breast cancer at the site of their original assessment. Concerns about the service had led to an external review of the breast screening unit by an independent body. The review team made a number of recommendations to improve the service. We found that the trust had implemented a number of technical and reporting improvements in response to the recommendations.

Cleanliness, infection control and hygiene

- The outpatient and diagnostics settings were visibly clean.
- The cleaning records for the departments confirmed that the environment was cleaned regularly and this was displayed publicly for patients to see.
- Regular hand hygiene audits demonstrated compliance rates in line with trust targets throughout the departments.
- Staff in the outpatients department complied with the trusts policies and guidance on the use of personal protective equipment and adhered to "bare below the elbow" guidance.

- The trust managers told us that there was an "I am clean" sticker system in operation to inform staff at a glance as to the cleanliness of equipment and furniture. We did not see evidence of this being used universally across all the departments we visited.
- In the physiotherapy department in medical one we found the treatment room floor was dirty particularly around clinical waste bin areas and waiting area chairs. At the time of our visit, we observed a patient was using the area with bare feet.

Environment and equipment

- We found the physiotherapy department in the medical one unit to be cramped for space and in poor state of repair. We had been told prior to our visit that this area was prone to flooding, this was confirmed by staff and evidence was seen where it had affected plaster on the walls in the corridor.
- An area used as an exit was cluttered with equipment and could block access in an emergency. We raised this with the staff at the time of our visit who removed the equipment.
- The location consisted of multiple buildings spread across the site. Some of the departments were located within the original hospital buildings whilst others were in a purpose built environment. We noted that space was limited in some areas and the service provision was physically constrained by the existing environment.
- The head of pathology told us the building work for a new purpose built pathology department was due to start within the next few weeks and was due for implementation in January 2016.
- Equipment within the departments had been portable appliance tested for electrical safety. All the staff we spoke with said that space was limited for the suitable storage of equipment. This was acknowledged by the trust and identified on the divisional risk register with short and longer term plans to address the issues of storage.
- Resuscitation trolleys were secure and sealed. Regular checks had been completed. However we noted that all the record logs were new and had commenced in June 2015 so we were not able to check on practice prior to this date.
- In the physiotherapy department we found resuscitation trolley defibrillator gel pads that were out of date (expiry date: 20/07/2015). It was recorded that this trolley had been checked and correct on 24 and 27 July 2015. There was no drip stand in the department although stated as equipment required. We were told by staff that patients visited the department with cardiac issues and there had been crash calls in the past 5 years though this was not frequent.
- The ophthalmology department had clear policies in place and appropriate external support for the safe use of lasers in the department.
- The hospital had two CT scanners and one MRI scanner. The department had a radiation protection 'local rules' policy in place to support safe use of this equipment.

Medicines

- Medicines were stored in locked cupboards and there were no controlled drugs or IV fluids held in the outpatient areas.
- Prescription pads were stored securely and there were monitoring systems in place to ensure their appropriate use.
- Medicines were stored appropriately. Temperature records were complete and contained minimum and maximum temperatures to alert staff when they were not within the required range.

Records

- At our last inspection we told the provider they must ensure the timely availability of case notes and test results in the outpatients department. We found that the outpatient departments were experiencing difficulties in obtaining patient records in time for clinic appointments. At this inspection we met with staff and managers who confirmed that the provider had invested heavily in the medical records storage and provision on site. At the time of our inspection the latest data provided by the trust was 96% availability for outpatient records and 98% for elective inpatients. Staff were very proud of the improvements they had achieved since our last inspection. They carried out audits to monitor the improvements.
- The trust had continued to roll out its "Paper Lite" project which ensured that electronic information was available for patients. This project was not yet fully implemented but staff were positive about the improvements in efficiency and effectiveness for outpatient services such as the availability of test results and timely access to information.

Outpatients and diagnostic imaging

- Audits showed that 96% of records were available for outpatients and 98% were available for elective inpatients.

Safeguarding

- Safeguarding policies and procedures were in place across the trust. These were available electronically for staff to refer to.
- There was a safeguarding lead at the hospital and radiology/diagnostic staff told us they were encouraged to contact the safeguarding lead if they had any concerns about patients Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately. Audits provided by the trust showed that the staff had followed the correct safeguarding process.
- The trust target for safeguarding training completion was 80%. Records showed that the outpatient service had achieved 98% compliance with adult safeguarding training (Levels 1 and 2), 98% compliance with level 1 safeguarding children and 92% compliance with level 2 safeguarding children. 98% of staff working in the radiology/diagnostic department had completed adult safeguarding training to level 2, and child protection training to level 2.

Mandatory training

- The majority of staff received access to training in a range of subjects including health and safety, infection prevention and control and manual handling. Mandatory training was delivered as a mix of e-learning and face to face training which staff said was adequate to meet their needs. Some staff told us accessing e-learning had practical difficulties as it was located on the intranet. Staff needed to access it through computers in the department, which was not always possible.
- The trust target for mandatory training was 80%. Records showed a mixed result in the numbers of staff who had completed their mandatory training. At the time of our inspection records showed that the service had met the trust targets for equality and diversity, fire safety, health, safety and welfare and infection prevention control. However completion rates for conflict resolution and resuscitation training were well below the trust target at 73% and 66%.
- We found that staff in the orthopaedic clinic had not completed any recent updates due to pressure of workload and staffing levels.

Assessing and responding to patient risk

- At our last inspection we found that that the trust previously had issues with the implementation of an electronic appointment booking system prior to 2011. At this inspection we found that patients' safety was being monitored on a regular basis in relation to delays in accessing appointments. An outpatient improvement group was in place to monitor and implement improvements in the management of patient appointments, in order to ensure care was provided in a safe and timely manner and to reduce risks such as delays in appointments (which in turn could cause delays in diagnosis and treatment).
- Policies and procedures were in place should a patient deteriorate or have an adverse reaction to drugs and preparations in the diagnostic and imaging department.
- If a patient became unwell in the outpatients department the service had a clear protocol to follow. Staff were able to talk about and demonstrate a good knowledge of emergency procedures.

Nursing staffing

- At our last inspection we told the provider that they must ensure staffing levels and skill mix in all clinical areas were appropriate for the level of care provided.
- The trust did not have a formal tool for calculating the number of nurses required in outpatients; however staff told us that they tried to ensure there were enough staff to provide chaperones for all patients in clinic. Managers determined the number of nursing staff required by the number of clinics running at any particular time but also the nature of the clinics.
- Staff told us they were able to plan rotas in advance to manage the workload. Staff felt that nursing numbers and skill mix overall met the needs of their patients.
- Outpatient staff had access to agency staff to ensure adequate staffing levels were available to support the needs of patients. The agency staff received an induction prior to working in the department. We found that as of May 2015 the sickness rate for outpatient staff was 6.5% which was higher than the trust average.

Medical staffing

Outpatients and diagnostic imaging

- At our last inspection we told the trust they should consider its investment into the diagnostic and imaging services to respond to increased demand. Staffing concerns were identified in radiology and dermatology, where there was a shortage of specialist staff. The trust was told they must continue to actively recruit medical and specialist staff in areas with identified shortfalls.
- At this inspection we found that the radiologist vacancies were identified on the divisional risk register as a high risk. There were ongoing vacancies within the radiology service. Managers told us that they were actively out to recruitment and had introduced the use of extended roles for advanced practitioners to help manage the case load. The service leads felt that there had been some improvements in staffing but the recruitment of experienced radiology staff remained a challenge.
- On the day of our inspection we found that the ultrasound department was staffed with twoanagers, four sonographers, fifteen support workers, two agency staff and two students.
- Breast screening was managed in a small, self-contained unit. Staff reported that they had been through a particularly difficult time due to staffing issues and professional tensions within the department. However the members of staff we spoke with all told us that they felt supported by the trust in this regard. They also acknowledged the technical and recording improvements implemented as a result of the independent review of the service.
- There was a sufficient number of medical staff to support outpatient services. We found that the clinics were covered by specialist consultants and their medical teams.

Allied Health Professionals

- At our last inspection we had told the trust that it should review its staffing investment to ensure that the allied health professional workforce is developed at the same pace as the nursing and medical workforce to meet the growing demand for services. At this inspection despite some improvement and the provision of temporary staff there was an ongoing shortage of occupational therapists.
- The need for additional occupational therapists had been identified and was on the divisional risk register. This had been reviewed on 24 July 2015 and still showed a high risk rating for therapy staff vacancies. We saw evidence that the trust had actively tried to recruit to vacancies and had recruited temporary staff at the Lancaster site to ensure that patients had access to specialist occupational therapy staff on the acute and short stay wards. The lack of appropriate therapy staff may impact on the safe and timely care for patients and have a potential impact on their rehabilitation and length of stay.

Major incident awareness and training

- There was a trust major incident plan which listed key risks that could affect the provision of care and treatment. There were clear instructions in place for staff to follow in the event of a major incident. We saw posters displayed giving advice to staff on how to use personal protective equipment in the event of a major incident. This showed that incident planning was visible to all staff throughout the trust.
- However with the exception of the consultants, staff we spoke with in the diagnostic departments did not know their role in the event of a major incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Patients attending the outpatient and diagnostic imaging departments received effective care and treatment. Care and treatment was evidence based on and followed national guidance. Radiology staff were able to explain their safety protocols and the local rules for use of equipment and practice. Good practice guidance was available and displayed throughout the department. Double reporting of scans was in place to promote accuracy in diagnostic reporting.

Competency assessments were in place for staff working in the radiology department along with temporary staff to the department. However, staff raised concerns about their competencies in CT scanning, due to their rotation into this area being hampered by staff shortages.

There was evidence of good multidisciplinary working in the outpatient and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well

together for the benefit of patients. We observed a joint foot clinic taking place between physiotherapy and an external podiatry provider. This clinic had been recognised by a national body as an example of good practice.

Evidence-based care and treatment

- Care and treatment followed evidence based national guidance. For example NICE guideline 101: management of chronic obstructive pulmonary disease (COPD). Services were following royal college guidance such as the Royal College of Pathologists' clinical guidelines for the management of abnormal blood results.
- NICE and best practice guidance was available to staff via the trust's intranet.
- Radiotherapy's guidance was a condensed version of national guidance and was easily accessible on the departments own database.
- Radiology staff were able to explain their safety protocols and the local rules for use of equipment and practice. Guidance was displayed throughout the department. Double reporting of scans was in place to promote accuracy in diagnostic reporting.
- The trust had developed integrated pathways in ophthalmology to ensure a consistent approach to care across the different locations managed by the trust.
- The pathology service was the first in its regional network to develop a fully integrated haemorrhagic fever protocol across the primary and secondary care partners. This meant that patients were treated in a timely and consistent manner irrespective of where the patient received treatment. The use of a consistent approach to clinical care is regarded as good practice.

Pain relief

- Records confirmed that patients' pain needs were assessed before undertaking any tests in the majority of cases.
- Staff were able to access appropriate pain relief for patients within clinics and diagnostic settings.
- Prescribed pain relief was monitored for efficacy and changed to meet patients' needs where appropriate.

Patient outcomes

- Diagnostic reference levels (DRLs) audits took place to ensure patients were being exposed to the correct amount of radiation for an effective, but safe scan for each body part and these showed appropriate exposure levels.
- Radiotherapy undertook both internal and external audits, which were mostly positive. These included system audits, such as equipment calibration, image review processes and British Standards Institute (BSI) assessment
- Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000) audits were conducted and the results provided by the trust demonstrated that the service was complaint.
- The outpatient departments participated in audits such as hand hygiene, cleanliness and record keeping. There was evidence of staff using the electronic patient record system to carry out electronic clinical audits. One audit had identified some issues regarding specific delays in an outpatient clinic. As a result actions had been taken to address the delays and to improve waiting times.
- On the day of our inspection a trust wide audit day was in progress when staff from the three trust locations met together to take part in clinical audit presentations and learning. Records confirmed that this was a regular diary commitment to ensure that opportunities for audit were in place across all the trust locations.
- Records of local audits demonstrated a high rate of compliance with good practice across the service.
- The pathology service was compliant with the national clinical pathology accreditation scheme.
- The follow up to new appointment rates for the Lancaster site were either the same as or only slightly worse than the England average. This meant that most patients were followed up appropriately and in a timely manner.

Competent staff

- Competency assessments were in place for staff working in the radiology department along with temporary staff to the department. However, staff raised concerns about their competencies in CT scanning, due to their rotation into this area being stopped by staff shortages. Staff shortages across the department had been identified on the trust's risk register and recruitment of new staff into vacant posts was ongoing.
- The majority of staff we spoke with confirmed that they received one-to-one meetings with their managers on a

monthly basis, which they found beneficial. Data provided by the trust showed that 72% of outpatient staff at band 7 and below and 98% of radiology staff had received an appraisal in the last twelve months. The use of appraisals is important to ensure staff have the opportunity to discuss their work load and any development needs or support required to help them carry out their role.
- Staff were also trained in meeting the needs of patients living with dementia.

Multidisciplinary working

- There was evidence of good multidisciplinary working in the outpatient and diagnostic imaging departments. Doctors, nurses and allied health professionals worked well together. We observed a joint foot clinic taking place between physiotherapy and an external podiatry provider. This clinic had been recognised by a national body as an example of good practice.
- Radiology and diagnostic services offered one-stop clinics in some specialties, such as those provided by the Breast Screening Unit (BSU). Patients attending the BSU could receive an ultrasound, mammogram and aspiration, dependant on clinical need. The clinic was staffed by specialist radiographers alongside a consultant. Specialist nurses offered a support service for patients.
- The Breast Screening unit had been the subject of an external review by Public Health England. There was work ongoing to implement the recommendations made by the review team to ensure that the service continued to meet National Minimum Standards.
- Letters were sent out by the outpatients department to people's GPs to provide a summary of the consultation and any relevant treatment management plan in a timely way.

Seven-day services

- Diagnostic clinics ran across six days at Lancaster Royal Infirmary. Weekend clinics were used to assist with waiting lists when demand was greater than clinic capacity.
- The outpatient service operated six days a week and had extended normal working hours. However most activity happened between Monday and Friday 9am-5pm.

Access to information

- Medical and nursing staff confirmed they had access to the information they required.
- Guidance and reporting information was readily accessible from the trusts intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Although staff reported that they had received training in the Mental Capacity Act 2005, we found that their knowledge was variable. Some of the staff could not demonstrate a sound knowledge of the principles inherent within the legislation.
- There was a varied level of understanding of the implications on their role and responsibilities that would result from a patient's lack of mental capacity. Most staff could not explain when an assessment might be indicated, how it would be requested or who would complete it. This meant a patient may not receive an appropriate assessment of their mental capacity or the support which may be indicated as a result.
- We reviewed six consent forms for surgical procedures. All the records were completed and scanned onto the electronic patient record appropriately.

Are outpatient and diagnostic imaging services caring?

Good

Outpatient and diagnostic services were delivered by caring, committed and compassionate staff. Patients were overwhelmingly positive about the way staff looked after them. Care was planned and delivered in a way that took account of patients' needs and wishes.

The trust had a number of clinical nurse specialists and lead nurses available to support patients in managing their condition. There was access to volunteers and local advisory groups to offer both practical advice and emotional support to both patients and those close to them throughout the department.

Compassionate care

- Patients said that staff had been polite and caring. Staff spoke with patients in a respectful manner and were open and friendly in their approach. We witnessed patients being treated with courtesy and dignity by

reception staff, who showed patients to side waiting areas when required. Copies of a "Dignity and Respect Policy" were available in each clinic room that explained to patients what they should expect when attending the service.

- We observed some instances where patients that attended clinic regularly had built good relationships with the staff that worked there.
- Staff could describe examples of how difficult messages were given to patients and those close to them both sensitively and privately. However we observed and the trust data confirmed that some patients were told to expect results by telephone. This not considered best practice. Patients should receive bad news face to face so that they can access emotional support in a timely manner. We noted that a complaint had been received from a patient with a concern about this practice.
- The service operated a continuous patient experience survey which patients were encouraged to complete, either during or following their visit to the department. We saw examples of completed surveys which were all positive.
- The Friends and Family Test, which assesses whether patients would recommend a service to their friends or family, showed that 96.5% of patients would recommend the service to family and friends.

Understanding and involvement of patients and those close to

- Patients told us they were aware of their condition and that the doctors and nurses had explained this clearly to them. Patients told us they felt well informed about their care and treatment and could make informed choices.
- We spoke with three patients who told us that the diagnostic tests they had undergone were explained and their consent was sought appropriately.
- Within the outpatient areas there was a range of information leaflets and literature available for people to read about a variety of conditions.
- Each patient we spoke with was clear about what appointment they were attending for, what they were to expect and who they were going to see.
- There was evidence in the clinical notes that patients and their relatives were involved in making decisions about care and treatment.

Emotional support

- The trust had a number of clinical nurse specialists and lead nurses available to support and reassure patients regarding the management of their condition.
- There was access to volunteers and local advisory groups to offer both practical advice and emotional support to both patients and carers.
- Three records we reviewed showed completed assessments for anxiety and depression appropriate to the clinical needs of the patients.

Are outpatient and diagnostic imaging services responsive?

Good

We found that some improvements had been made to the outpatient and diagnostic service since our last inspection.

Overall access to appointments had improved but performance was variable. The percentage of people waiting less than 31 days and 62 days from diagnosis to first definitive treatment for all cancers varied. In quarter 4 (January to March 2014) 2013/2014 the trust performed worse than the national average but from quarter 1 to quarter 3 2014/2015 the trust performance improved and they performed slightly better than the England average. Diagnostic waiting times were generally better than the England average with the exceptions of April and October 2014 and January 2015. The Did Not Attend rates were consistently lower than the England average with an average of 6% for the hospital compared to 7.2% nationally. This was continually monitored to enable adaptations to be made to meet the needs and demand of the population.

The outpatient and radiology/diagnostic departments were able to access telephone translation services for patients. Staff told us that this could be arranged without notice when patients who required the service presented themselves in clinic.

The environment and ability to ensure privacy and dignity for patients impacted on service delivery. Patients told us that parking was an issue at the Lancaster site and signage to certain departments such as "medical one "physiotherapy was limited with no access to nearby disabled or public parking. As part of our previous inspection we noted that there was no information

available in the departments for patients who have a learning disability or written information in formats suitable for patients who had a visual impairment. In the course of this inspection we noted that this was not the case. Main outpatient and the Occupational Therapy department had specific information and leaflets for patients with learning disabilities. Main Outpatients and the Ophthalmology department had leaflets in an easy read formats; or written in formats suitable for those patients who have a visual impairment . However, staff we spoke with in outpatient departments across the site were not able to tell us how written information in an 'easy read' format could be accessed.

Service planning and delivery to meet the needs of local people

- The trust served a geographical area of 1000 square miles. The trust's outpatient and diagnostic imaging services were located throughout the geographical area to facilitate access to clinics and reduce travel times for people using the services.
- Extra clinics were held at weekends to reduce waiting times for patients.
- Some services such as dietetics were piloting telephone clinics to reduce the need for patients to travel. We noted that this was not always suitable for each patient and this was being monitored for efficacy.
- Some staff felt that although they were encouraged to work as one trust there were still issues in inequalities of service delivery. For example we found that the physiotherapy input input for cardiac rehabilitation on the Lancaster site was different to the provision at other trust locations which was not in line with national guidance. The lack of streamlined provision may impact on the effectiveness and appropriateness of service delivery.
- Due to reception desks being in waiting areas we found that patients' personal details could be overheard when staff were booking them in.
- Patients told us that parking was an issue at the Lancaster site and signage to certain departments such as the physiotherapy service located in medical unit one was limited with no access to nearby disabled or public parking.

Access and flow

- According to Hospital Episode Statistics, between January 2014 and December 2014 the outpatients department at the Royal Lancaster Infirmary (RLI) had held 296, 701 appointments
- The referral to treatment rates (percentage within 18 weeks) for non-admitted and incomplete pathways were better than the expected standard from April 2013 to December 2014 but fell below the standard for incomplete pathways in January 2015. In the same timeframe, the trust performed better than or similar to the England average.
- Diagnostic waiting times were generally better than the England average with the exceptions of April and October 2014 and January 2015.
- The percentage of people waiting less than 31 days and 62 days from diagnosis to first definitive treatment for all cancers varied. From quarter 1 to quarter 3 of 2013/2014 the trust performed in line with the England average. In quarter 4 of 2013/2014 the trust performed worse than the national average but from quarter 1 to quarter 3 2014/2015 the trust performance improved and they performed slightly better than the England average.
- The percentage of people seen by a specialist within 2 weeks, urgent GP referral (all cancers) was similar to the national average (2013/2014 to 2014/2015).
- Changes to the management of the waiting list meant those that had been waiting longest were now being offered the quickest appointments. This meant fewer patients were waiting extended periods. The average percentage of clinics cancelled from January to April 2015 was 0.6%.
- The trust had a number of patients who failed to attend for their appointments. The Did Not Attend rates were consistently lower than the England average with an average of 6% for the hospital compared to 7.2% nationally. This was continually monitored to enable adaptations to be made to meet the needs and demand of the population.
- During our last inspection we noted that the trust needed to improve the waiting times for patients once they arrived in the department. Staff were able to describe how they had responded to an identified delay in ENT clinics and how they had put systems in place to reduce the waiting times for patients. Data provided by the trust showed that 1% of patients waited up to 30 minutes for their appointment in the last four months and only 1% of patients waited over 60 minutes.

Outpatients and diagnostic imaging

- We also noted at our last inspection that there were a number of incidents regarding transport for patients. We spoke with patients and external staff who confirmed that this had improved over the last twelve months. The location had reported only three incidents in the last six months regarding transport issues for the RLI site. Patients we spoke with told us that things seemed to have improved recently.

Meeting people's individual needs

- The disabled access to the rear of the department was not signposted, was difficult to find and patients had to travel a considerable distance to the gym and treatment room.
- The outpatient and radiology/diagnostic departments were able to access telephone translation services for patients. This could be arranged without notice when patients who required the service were in clinics. However we did not see any information regarding translation services for patients who may require them.
- As part of our last inspection we noted that there was no information available in the departments for patients who have a learning disability. We could not find information available in easy to read formats; or written information in formats suitable for patients who had a visual impairment. In the course of this inspection we noted that there was information available for people with learning disabilities or those with a visual impairment. Main outpatient and the Occupational Therapy department had specific information and leaflets for patients with learning disabilities. Main Outpatients and the Ophthalmology department had leaflets in an easy read formats; or written in formats suitable for those patients who have a visual impairment . However, staff we spoke with in the outpatient departments across the site were not able to tell us how written information in an 'easy read' format could be accessed when required.
- There was a discreet trust wide system for the identification of patients living with dementia who may require additional assistance.
- In the medical one building there were issues with access for patients. The lift was not working and the Trust told us that the lift had been decommissioned following a risk assessment. The Trust told us patients and the public have access to two of the remaining patient, visitor and staff lifts in medical unit one. Staff told us that the department had been due to close in 2014 staff could not tell us when the department was due to be closed or any future plans for the department at the time of our inspection. We found that patients with limited mobility and patients attending for cardiac rehabilitation were still attending the department this was not in line with the trust information that physiotherapy staff assess patients, and send those with mobility problems to MU2 so that only patients who are able to negotiate steps are sent to the MU1 unit.
- Vulnerable patients were managed sensitively and attended to as quickly as possible.

Learning from complaints and concerns

- Trust data for the time period 1st June 2014 – 31st May 2015 showed that 24 complaints had been received which were related to the outpatient service.
- Concerns or complaints leaflets and information about the patient advice and liaison service was available throughout the departments we inspected. The response target for complaints was 35 working days from receipt of the complaint which data showed was currently being met.
- We saw copies of the latest "Learning to improve" bulletin. This bulletin highlighted the ways the organisation had considered complaints and changed or improved things. One area highlighted in the bulletin related to the outpatient department included reminding all staff about the importance of informing patients of any delays during clinic.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

Since our last inspection there had been a review into the Breast Screening Unit (BSU) by Public Health England. The review was initiated after concerns were raised by staff regarding the quality of practice in the breast screening service provided by the trust. The review findings were published in November 2014 and made a number of recommendations for action. As part of this inspection we noted that the trust was making progress in implementing the recommendations.

Senior managers told us the service had experienced issues with effective team working and had challenges in building

team resilience and communication. They had engaged an external consultant to work with the teams to reduce tensions and build constructive relationships. We found examples of temporary leadership roles in place due to staffing vacancies which had led to difficulties in driving forward service innovation and improvement. There was a feeling from staff that different areas of the Radiology and Diagnostic service worked in isolation and we saw examples when staff were reluctant to assist patients who were attending other areas.

Service leads told us that there was an operational plan for the outpatient and diagnostic services but we did not see evidence of this being shared with staff. We found that risks identified during our inspection were on the risk register although we did not see evidence of clear plans to mitigate the identified risks. For example the physiotherapy department had been on the risk register for three years with no clear action plan to resolve the issues.

Vision and strategy for this service

- The trust's vision of, "better care " for the future across the region was displayed throughout the service. All of the staff we spoke with were aware of the trust's vision and values. Service leads told us that there was an operational plan for the outpatient and diagnostic services but we did not see evidence of this being shared with staff.

Governance, risk management and quality measurement

- At our last inspection we found that the trust's governance and management systems were not fully embedded in all parts of the service and not all services were following trust policies and procedures. At this inspection we found that improvements had been made.
- There were systems to report and manage risks. Staff were encouraged to participate in changes within the department and there was departmental monitoring at both consultant and board level in relation to patient safety. The service held monthly core clinical governance and assurance meetings with standard agenda items such as incident reporting, complaints, training and lessons learned.
- The outpatient service reported risks through the core clinical services division. Senior staff were aware of the risk register and were actively engaged in monitoring the risks. We found that risks identified during our inspection were on the risk register although we did not see evidence of clear plans to mitigate the identified risks For example the physiotherapy department had been on the risk register for three years with no clear action plan to resolve the issues.
- The need for additional occupational therapists had been identified and was on the divisional risk register. This had been reviewed on 24 July 2015 and still showed a high risk rating for therapy staff vacancies.
- Radiology consultants attended monthly directorate clinical governance and risk meetings to review the quality of service provision and ensure that the standard of clinical care was effective and in line with national standards.
- Since our last inspection there had been a review into the Breast Screening Unit (BSU) by Public health England. The review was initiated after concerns were raised by staff regarding the quality of practice in the breast screening service provided the trust. The review findings were published in 2014 and outlined that the service was meeting national minimal standards; however there were quality issues in the service that needed addressing. As part of this inspection we noted the recommendations given to the trust were being followed.

Leadership of service

- However we had both positive and negative feedback about the visibility of middle managers. The recent reorganisation across therapy services had caused some uncertainty and staff felt they did not know their new managers.
- We found examples of temporary leadership roles in place due to staffing vacancies which had led to difficulties in driving forward service innovation and improvement. This was a particular issue in the Breast Screening Unit.
- Staff told us that the executives were more visible and showed examples of regular communication and feedback.

Culture within the service

- The independent review of the Breast Screening Service indicated that there were ongoing issues with effective team working and there were challenges in building

team cohesion, resilience and communication. An external consultant had been to work with the teams to reduce inter-personal tensions and build constructive relationships.

- This approach had not secured the desired improvements. Relationships within the service remained fragile and tense. There was still work for the trust to do to ensure that relationships within the service and with its surgical colleagues were productive and based on mutual professional trust.
- This had had an impact on securing the required management changes in the service. At the time of our inspection interim management arrangements were in place that required consolidation to take the service forward.
- We noted that staff evaded answering questions relating to how systems worked across the three main hospital sites we visited during our inspection. One member of staff we spoke with in the Breast Screening Unit told us they did not know their colleagues on other sites. During our conversation, the staff member was unable to tell us the surname of a colleague in an equivalent role on another site.
- Some staff said that when they tried to present any 'alternative' views to senior management they had largely been ignored and that some of the systems in place did not support them. This view had been expressed to us before and during our previous inspection in 2014.

Public engagement

- The trust was proactive in seeking patient feedback within the outpatient services. We found feedback forms available in all the departments we visited with post boxes for patients and visitors to leave the completed forms. Patients told us they were actively encouraged provide feedback.
- We looked at a sample of ten completed cards that were all positive about the care people had received.
- Information was displayed on message boards throughout the outpatient services to engage the public in messages about the service as well as to seek feedback.

Staff engagement

- Overall staff felt more engaged with the trust and felt that there had been some improvements in service delivery.
- However it was evident that the trust still had work to do in supporting staff to feel 'heard' and embedding the 'Listening in Action' initiative in the outpatients department.

Innovation, improvement and sustainability

- Strategies for service improvements were in place in both diagnostics and outpatients. However staff we spoke with had variable knowledge regarding strategies for improvements across the department.
- We were shown minutes from the outpatient improvement group and staff were able to describe initiatives they had implemented such as the outpatient contact cards to improve communication with patients attending the outpatient department. Staff told us that the group was continuing to be proactive in looking at ways to improve service delivery.
- The service had also started to develop a patient passport and an advisory leaflet for patients when they wish to cancel appointments as part of the trusts Access Policy.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- The provider must ensure that all premises used by the service provider are suitable for the purpose for which they are being used and properly maintained. This is particularly in relation to physiotherapy services and medical care services provided from medical unit one.
- The provider must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are deployed in order to meet the needs of the patients. Staff should receive appropriate support, training and appraisal as is necessary to enable them to carry out their role.
- The provider must ensure that staff understand their responsibilities under and act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.
- The provider must ensure that staff follow policies and procedures around managing medicines, including intravenous fluids particularly in medical care services and critical care services.
- The provider must ensure that the resuscitation trolleys on the children's ward are situated in areas that make them easily accessible in an emergency. All staff must be clear on who has responsibility for the maintenance of the resuscitation trolley on the delivery suite.
- The provider must ensure that they maintain an accurate, complete and contemporaneous record in respect of each service user, particularly in relation to the monitoring of fluid intake and completion of medical notes in medical care services.
- The provider must ensure that the Five Steps to Safer Surgery (World Health Organisation) safety checklist is consistently followed and fully embedded in obstetric theatre practice.
- The provider must ensure that all staff comply with hand hygiene requirements.
- Ensure referral to treatment times in surgical specialities improve

the hospital SHOULD take to improve

In urgent and emergency services:

- Ensure all areas in the emergency department are clean and free from dust and debris and that mattresses are fit for purpose..
- Take action to improve waiting times and ambulance handovers.
- Ensure action plans following College of Emergency Medicine audits clearly state the steps required to secure improvement.
- Improve staff engagement, knowledge and awareness of the strategy for the service.

In medical care services:

- Ensure that call bells are easily accessible for patients so they can call for help when required.
- Ensure there are clear plans in place to reduce the number of falls occurring within the service.
- Improve the management of people with a stroke in line with national guidance.
- Consider improving arrangements for clinical supervision to ensure they are appropriate and support staff to effectively carry out their responsibilities, offer relevant development opportunities and enable staff to deliver care safely and to an appropriate standard.
- Take action to improve reduce the number of patients staying on medical wards that are not best suited to their needs and to reduce the number of moves between wards.

In surgical services:

- Ensure there are systems in place to identify themes from incidents and near miss events to promote safe care.
- Ensure all theatres are completing audits to monitor compliance with the 5 steps to safer surgery process.
- Ensure all staff understand the process for raising safeguarding referrals in the absence of the safeguarding lead.
- Reduce and improve readmission rates.
- Ensure all procedures are performed in line with best practice guidance. Where practice deviates from the guidance, a clear risk assessment should be in place.

Outstanding practice and areas for improvement

- Continue to engage staff and encourage team working to develop and improve the culture within the theatre department.

In critical care services:

- Ensure that there is timely access to medical care for patients out of hours and that any delays do not result in patient harm.
- Consider how it is going to improve performance in reducing the number of delayed and out of hours discharges of patients from critical care.
- Ensure that any delayed discharges from critical care do not result in a breach of the government's single sex standard.
- Ensure that all entries in patient records are appropriately signed and dated.
- Consider the provision of a supernumerary clinical coordinator on duty 24/7.
- Consider how it intends to respond to the latest Health Building Notes guidance for critical care units in planning its vision and strategy for the service.

In maternity and gynaecology services

- Ensure that the actions of the Kirkup recommendations are implemented within timescales and embedded across the trust
- Ensure there are clear lines of responsibility and accountability at ward manager and matron level within maternity so that staff feel supported and barriers to communication and change are removed
- Implement the recommendations of and monitor compliance with, the PHSO Report 'Midwifery supervision and regulation: recommendations for change' (2013) with regard to Trust/Midwifery Supervisory investigations, so that parent(s) receive a joint set of recommendations and a single timeframe resulting from the investigation
- Ensure that a physical test is carried out in line with trust policy to ensure that the infant abduction procedures work correctly and that staff understand how they work

n children and young people's service

- Ensure that there are clearly defined and formalised job plans in place for consultant paediatricians.
- Consider reviewing the investigation process of patient safety incidents with full consideration given to the reporting professional's account of events and concerns.
- Ensure there is sufficient and appropriate access to oxygen points on the neonatal unit in line with BAPM standards.

In end of life care services

- Ensure there is a clear and accessible system in place to identify and monitor risks within end of life care services.
- Continue to take action to improve those areas identified by the NCDAH.
- Ensure all DNACPR forms are completed to the appropriate standard.

In outpatients and diagnostic imaging:

- Continue to build relationships and develop closer team working to develop a one trust culture.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12: Safe care and treatment.** **Care and treatment was not always provided in a safe way through the assessment of risks to the health and safety of service users of receiving care and treatment.** **This is because assessment, planning and delivery of care and treatment were not always carried out in accordance with the Mental Capacity Act 2005. Staff did not always understand their roles and responsibilities in relation to the Mental Capacity Act 2005.** **HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12, (2) (a)**

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 12: Safe care and treatment.** **Care and treatment was not always provided in a safe way through the proper and safe management of medicines.**

This section is primarily information for the provider

Requirement notices

This is because staff did not always follow policies and procedures related to the storage and administration of medicines, particularly in A&E, medical care services, critical care and children and young people's services. Medicines management policies available to staff in surgery services were not in date.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12, (2) (g)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 15: Premises and equipment

All premises used by the service provider were not suitable for the purpose for which they were being used or properly maintained. This is in relation to physiotherapy services and medical care services provided from medical unit one.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 15, (1) (c) (e)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17: Good governance

This section is primarily information for the provider

Requirement notices

The service did not monitor and mitigate risks relating to the health, safety and welfare of people who used the service.

The resuscitation trolley on the children's ward was situated in an area that was not easily accessible in an emergency. This had been identified at the previous inspection but was still a concern. Staff were not clear on who had responsibility for the maintenance of the resuscitation trolley on the delivery suite.

Five Steps to Safer Surgery (World Health Organisation) safety checklist was not consistently followed and fully embedded in obstetric theatre practice. In maternity services, medical staff did not always comply with hand hygiene requirements. 17 2b

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 17, (2) (b)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 17: Good governance.

The service did not maintain an accurate, complete and contemporaneous record in respect of each service user.

This is because the level of completion of records throughout the hospital varied. In particular, completion of fluid intake charts and medical notes in medical care services was variable. In A&E, nursing notes were minimal and pain scores and patient allergy status were not consistently recorded.

This section is primarily information for the provider

Requirement notices

Ensure referral to treatment times in surgical specialities improve.

HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 17, (2) (c)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 18: Staffing There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the needs of the patients. This is because there were shortages of nursing and medical staff in several areas throughout the hospital, particularly in A&E, medical care services, children and young people services and surgical services. Mandatory training completion levels and appraisal rates were variable across the service. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 18, (1) and (2)(a)